Health Insurance Risk Sharing Plan (HIRSP)

2003 Annual Report

Prepared by:

HIRSP Board of Governors
and
Wisconsin Department of Health and Family Services
Division of Health Care Financing

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Executive Summary

Demographics

- Health Insurance Risk Sharing Plan (HIRSP) enrollment continued to rise in 2003. As of December 31, 2003, 17,447 people were enrolled in HIRSP. This represents an increase of 9.9% in end-of-year enrollment over the 2002 end-of-year enrollment of 15,882. Average enrollment for the year increased by 15%.

- Plan 1, Option B showed the greatest percentage increase in growth during 2003, increasing from 5,438 in 2002 to 7,286 in 2003, a rate of 34%. Plan 1, Option A experienced a 3% decrease from 8,711 in 2002 to 8,421 in 2003. Plan 2 enrollment remained steady, increasing from 1,733 to 1,740.

- Applications to HIRSP in 2003 decreased from 2002; the program received an average of 540 applications per month in 2003 versus an average of 597 per month in 2002. Applications averaged 455 in 2001, and 420 in 2000.

- A total of 60.0% of individuals approved for HIRSP qualified because of a rejection for health insurance coverage from a commercial insurer, compared with 63.9% in 2002. Thirty six percent (36%) of individuals approved for HIRSP qualified under the Health Insurance Portability and Accountability Act (HIPAA).

- In 2003, 39% of eligible HIRSP policyholders qualified for premium and/or deducible reductions because they reported an annual household income of less than $25,000.

- The percentage of policyholders that are receiving reductions has remained relatively constant. Subsidies are not available to Plan 1, Option B policyholders.

Financial Overview and Cost Sharing

- State general purpose revenue appropriations for HIRSP ended as of July 1, 2003, changing the funding of program costs to be divided between policyholders, providers, and insurers in a 60%/20%/20% ratio, respectively. In addition, providers and insurers each fund 50% of all costs or reductions in premium, deductible and drug coinsurance. (also referred to as subsidies)

- Total plan costs, which include administrative and claims costs, for calendar year 2003 were $131.4 million. By law, at that time, these costs were funded by a combination of general purpose revenue, policyholder premiums, assessments paid by insurance companies writing health insurance policies in Wisconsin, and reduced payments to providers. Total plan costs in 2003 (including subsidy costs) were 25% higher than 2002 costs. The program' s average cost per HIRSP policyholder increased by 8.6% to $7,725 per year. (Refer to Appendix 7)

- On average, individuals enrolled in HIRSP pay approximately half of the actual cost for their benefit coverage after the cost of subsides is excluded. In 2003, HIRSP policyholders' average out-of-pocket payment for premiums was $4,277 (55.4%) of the average $7,725 cost per HIRSP policy. Total administrative and claims costs in 2003 were $131,358,386 and of those costs, the total cost to other payers represented by Wisconsin policyholders was $58,619,771 (44.6%). The average cost of a HIRSP policy not covered by premiums paid by HIRSP policyholders was 1% greater than it was in 2002. (Refer to Appendix 7)

Utilization and Costs

- HIRSP has paid out $10,000 or less in benefits for 76% of policyholders since the program's inception.

- In 2003, HIRSP paid out $10,000 or less in benefits for 88% of policyholders.

- In 2003, HIRSP paid $0 in benefits for approximately 8.0% of policyholders and more than $50,000 in benefits for 1.2% of policyholders.

- The most costly diagnosis category for HIRSP policyholders is Circulatory System Diseases, such as Atherosclerosis and Ateriosclerotic heart disease, which constituted 20.2% of all medical claims expenditures in 2003.

- Lipotropics[1] is the most costly therapeutic classification of drugs paid by HIRSP for policyholders in 2003, constituting 8.3% of all prescription drug expenditures.

[1] Describes a substance that promotes the transport of fatty acids from the liver to tissues or accelerates the utilization of fat in the liver itself.

Overview

The Wisconsin HIRSP is a health insurance program for Wisconsin residents who either are unable to find adequate health insurance coverage in the private market due to medical conditions or who have lost their employer-sponsored group health insurance.

Administration

The Department of Health and Family Services (DHFS) is responsible for the oversight and administration of HIRSP. Under DHFS oversight and as required by state law, HIRSP' s plan administrator, the Medicaid fiscal agent, carries out daily operational duties such as eligibility determination, claims processing, and premium billing functions.

Also in accordance with state law, HIRSP has a Board of Governors consisting of 13 individuals. The Secretary of the DHFS or the Secretary' s designee chairs the Board of Governors. Members also include the Commissioner of Insurance or Commissioner' s designee and representatives of the following who are appointed by the Secretary and serve staggered three-year terms (refer to Appendix 1 of this report for a list of HIRSP Board members):

- Two participating insurers from nonprofit corporations.
- Two other participating insurers.
- Three health care provider representatives, including one representative from the Medical Society of Wisconsin, one representative from the Wisconsin Health and Hospital Association, and one representative of an integrated multidisciplinary health system.
- Four public members who are not professionally affiliated with the practice of medicine, a hospital, or an insurer. One member must be a representative of small businesses in the state, and one member must have coverage under the plan.

The Board is responsible for approving the program budget prepared by the DHFS, approving administrative contracts, overseeing performance standards for the plan administrator, collecting assessments from insurers, advising the DHFS on choice of coverage, and other duties outlined in law.

The Board of Governors established three HIRSP committees: the Financial Oversight Committee (FOC), the Grievance Committee, and the Legislative Issues Committee. The FOC is responsible for monitoring all HIRSP financial matters and making recommendations to the full Board. An Actuarial Advisory Subcommittee, which operates as a subcommittee of the FOC, provides recommendations on industry standard rates. The Grievance Committee is responsible for reviewing all policyholder grievances and deciding the resolution of the grievances. The Legislative Issues Committee is responsible for reviewing legislative matters that affect HIRSP and making recommendations to the full Board. In addition to these three Board committees, in early 2003 the Board reactivated the Consumer Affairs Committee. This committee is responsible for helping to improve communications to policyholders.

Funding

Sources of HIRSP Funding

- State tax collection or general purpose revenue (GPR) funds were appropriated under the state budget to offset HIRSP costs through state fiscal year 2003. In 2003, $4.8 million in GPR was appropriated for HIRSP. The GPR appropriation for HIRSP was eliminated in the state fiscal year (SFY) 2004 budget. Policyholders, providers, and insurers now fund 100% of program costs.

- Policyholder premiums must, by law, fund 60% of the balance of HIRSP costs (excluding subsidies) after the GPR appropriation offset has been applied but may not be less than 140% nor more than 200% of a standard risk rate. When the standard risk rate criterion results in the collection of premiums greater than the 60% policyholder funding share, excess premium revenue accrues and is reserved to offset future rate increases.

- Insurers and health care providers (excluding pharmacy providers) each cover 20% of the balance of HIRSP costs after the GPR appropriation offset has been applied:

  - ✓ Insurers pay their 20% through assessments charged to insurance companies. Insurer assessments for CY 2003 funded $26,934,885 of reconciled HIRSP costs. (Refer to Appendix 5 [Adjusted Program Costs Including Subsidy Costs] and Appendix 7.)

  - ✓ Health care providers pay their 20% through reimbursement reductions in HIRSP claim payments. Pharmacy providers are exempt. Provider rate reductions for CY 2003 funded $26,934,890 of reconciled HIRSP costs. (Refer to Appendix 5 [Adjusted Program Costs Including Subsidy Costs] and Appendix 7.)

Annual reconciliation of plan costs ensures that the funding formula remains in balance and that policyholders, insurers, and providers contribute their required respective 60/20/20% level of plan funding after application of the GPR funding offset.

The insurance industry and providers each contribute 50% of the needed amount to cover any premium and deductible subsidy costs in excess of the appropriated GPR. Since there is no longer GPR appropriated for HIRSP subsidies, the total subsidy costs of $4,914,091 are now funded equally by insurers and providers.

Refer to the *Funding* chapter of this report for a more detailed discussion of funding.

Section 149.15, Wisconsin Statutes, requires that HIRSP define in its annual report the cost of the plan to all policyholders in this state. Other than the premiums paid by HIRSP policyholders, GPR appropriations, insurer assessments, and discounted provider payment rates comprised the funding sources for the program in 2003. Those amounts are ultimately paid by Wisconsin taxpayers and by other policyholders throughout the state. For calendar year 2003, the total cost borne by GPR appropriations, insurer assessments, and discounted provider payment rates was 44.6% of plan costs, $58,619,771, or $3,447 per HIRSP policy.

Funding Sources*

	CY 1999	CY 2000	CY 2001	CY 2002	CY 2003
Avg. number HIRSP policyholders	7,561	9,154	11,694	14,775	17,005
Total plan costs	$50,107,757	$54,451,356	$76,451,816	$105,111,061	$131,358,386
Avg. cost per HIRSP policy	$6,627	$5,948	$6,538	$7,114	$7,725
HIRSP policyholder payments	$21,994,320	$24,438,916	$37,742,390	$54,679,800	$72,738,615
Total avg. annual premium per HIRSP policyholder	$2,909	$2,670	$3,228	$3,701	$4,277
HIRSP policyholder % of costs	43.9%	44.9%	49.4%	52.0%	55.4%
Total cost to non-HIRSP policyholders	$28,113,437	$30,012,440	$38,709,426	$50,431,261	$58,619,771
Cost to non-HIRSP policyholders per HIRSP policyholder	$3,718	$3,279	$3,310	$3,413	$3,447
Percent of costs to non-HIRSP policyholders	56.1%	55.1%	50.6%	48.0%	44.6%

*Refer to Appendix 7 of this report for details of HIRSP costs by funding source.

Eligibility

Generally, to be eligible for HIRSP, applicants must be under age 65 (limited exceptions apply), be a resident of Wisconsin, and meet one or more of the following requirements:

Plan 1, Options A and B eligibility:

- Have received a notice of rejection, cancellation, or reduction in benefits from one or more health insurers (due to health reasons) within nine months prior to making application for coverage.

- Be an "eligible individual" as defined under s.149.10 (2t), Wis. Stats., and submit a valid certificate of "creditable coverage" under a qualifying group health plan from a previous health insurer.

- Have tested positive for the Human Immunodeficiency Virus (HIV).

Plan 2 eligibility: Applicants must either be eligible for Medicare due to a disability or be a current policyholder who turns age 65 while enrolled in HIRSP.

Please refer to Appendix 2 of this report for a detailed description of HIRSP' s eligibility requirements.

Health Plans

HIRSP offers the following plans:

- **Plan 1, Options A and B,** are for people who are not eligible for Medicare. Both options have identical benefit coverage that differs only in premium amounts, deductibles, and coinsurance. Option A offers a lower deductible and lower drug coinsurance out-of-pocket maximum, while Option B offers lower premiums.

- **Plan 2** is available for applicants who:
  - ✓ Qualify for Medicare due to a disability and are younger than age 65, or
  - ✓ Qualify for Medicare and reach age 65 while enrolled in HIRSP.

The following table presents a detailed comparison of the HIRSP plans.

HIRSP Health Plan Comparison

	Plan 1, Option A	Plan 1, Option B	Plan 2
Premiums	Refer to Appendix 3.	Refer to Appendix 3.	Refer to Appendix 3.
Premium reductions available if you qualify	Yes.*	No.	Yes.*
Medical deductible	**$1,000** per year.	**$2,500** per year.	**$500** per year.
Medical deductible reductions available if you qualify	Yes.**	No.	No.
Medical coinsurance	**20%** of allowed amount **$1,000** total per year.	**20%** of allowed amount **$1,000** total per year.	No.
Individual medical out-of-pocket maximum (Total expenditures for medical deductible and medical coinsurance, after which HIRSP will pay at 100%.)	**$2,000** per year. This does not include drug coinsurance.	**$3,500** per year. This does not include drug coinsurance.	**$500** per year. This does not include drug coinsurance.
Family medical out-of-pocket maximum (All family members must be on the same plan for these amounts to apply.)	**$4,000** per year. This does not include drug coinsurance.	**$7,000** per year. This does not include drug coinsurance.	**$1,000** per year. This does not include drug coinsurance.
Drug coinsurance Effective January 1, 2002	**20%** of the allowed amount up to a maximum of **$25** per prescription.	**20%** of the allowed amount up to a maximum of **$25** per prescription.	**20%** of the allowed amount up to a maximum of **$25** per prescription.
Drug coinsurance out-of-pocket maximum Effective January 1, 2002 (Total expenditures for drug coinsurance, after which HIRSP will pay at 100%.)	**$750** per year. This is in addition to medical coinsurance.	**$1,000** per year. This is in addition to medical coinsurance.	**$125** per year. This is in addition to medical coinsurance.
Drug coinsurance out-of-pocket maximum reductions available if qualified Effective January 1, 2002	Yes.**	No.	No.
Maximum lifetime benefit	**$1,000,000**.	**$1,000,000**.	**$1,000,000**.

* Available for policyholders with household incomes of less than $25,000.
** Available for policyholders with household incomes of less than $20,000.

HIRSP premiums are based on the policyholder' s age, gender, and zone of residence. Premium and/or deductible reductions are available to low-income policyholders in Plan 1, Option A and Plan 2.

Covered Services

HIRSP will cover medically necessary and appropriate services consistent with the HIRSP policy only when those services are received from Wisconsin Medicaid-certified providers. All benefits are subject to the exclusions, limitations, and conditions of the HIRSP policy. The following is a partial list of services that HIRSP covers:

- Hospital services.
- Basic medical-surgical services, including in-hospital and out-of-hospital medical and surgical services, diagnostic services, anesthesia services, and consultation services.
- Inpatient treatment and outpatient services for substance abuse (alcohol or other drug abuse) and nervous and mental disorders.
- Prescription drugs and insulin.
- Home care.
- Durable medical equipment.
- Disposable medical supplies.
- Diagnostic X-rays and laboratory tests.
- Physical therapy services.
- Emergency ambulance services.
- Skilled nursing facility services.
- Hospice care.
- Services and supplies for treatment of diabetes.
- Chiropractic services.
- Maternity and newborn services.

Services Not Covered

The following is a partial list of treatments, services, supplies, and expenses that HIRSP does not cover:

- Routine exams and related services.
- Cosmetic treatments.
- Eyeglasses.
- Hearing aids.
- Routine dental care.
- Custodial care.
- Infertility, impotence, and sterility services or drugs.
- Charges for procedures or services that are determined as not medically necessary and appropriate.

- Expenses incurred for procedures or services that are of questionable medical value, experimental, or investigative (except drugs for the treatment of HIV infection).

Policyholder Cost Sharing

Premiums

Consistent with other health insurance plans, all HIRSP policyholders are required to pay premiums for their coverage.

In 2003, state law required that policyholder premiums fund 60% of plan costs remaining after a GPR appropriation has been subtracted. The law also required that premiums be set no higher than 200% and no lower than 140% of the rate that a "standard risk" person would pay for comparable coverage in the private market. When premiums at 140% of the standard rate fund more than 60% of plan costs, excess premium revenues accrue. State law restricts the use of excess premium revenue.

HIRSP statutes provide for reduced premiums for qualifying Plan 1, Option A and Plan 2 policyholders with annual household incomes below $25,000. The reductions are partially funded by GPR, with the insurance industry and providers funding the remaining amount.

Refer to Appendix 3 of this report for HIRSP' s 2003 annual full premium tables and to Appendix 4 of this report for a detailed explanation of the methodology for calculating HIRSP premium rates.

Medical Deductibles and Coinsurance

In addition to their premiums, all Plan 1, Options A and B policyholders are required to satisfy medical deductible and coinsurance amounts, which are calendar-year based and vary by option. Once the deductible and coinsurance out-of-pocket maximums have been met, HIRSP pays 100% of covered expenses for the remainder of the calendar year. Plan 2 policyholders do not pay medical coinsurance and are required to satisfy only calendar-year deductibles. Deductible and coinsurance amounts for all plans are set in state law.

Plan 1, Option A policyholders pay the first $1,000 of covered expenses in each calendar year as a medical deductible. Policyholders with qualifying income levels pay reduced deductibles. After the medical deductible has been met, policyholders pay 20% of the allowed amount of covered expenses as medical coinsurance, up to a maximum of $1,000. Once the medical coinsurance out-of-pocket maximum has been met, HIRSP pays 100% of allowed costs for the remainder of the calendar year.

Plan 1, Option B policyholders pay the first $2,500 of covered expenses in each calendar year as medical deductible and are not eligible for reductions. Plan 1, Option B policyholders pay a higher medical deductible in exchange for lower premiums. After the medical deductible has been met, policyholders pay 20% of the allowed amount of covered expenses as medical coinsurance, up to a maximum of $1,000. Once the medical coinsurance out-of-pocket maximum has been met, HIRSP pays 100% of allowed costs for the remainder of the calendar year.

Plan 2 policyholders pay the first $500 of covered expenses as medical deductible and are not eligible for deductible reductions. Plan 2 requires no medical coinsurance; therefore, HIRSP pays 100% of covered medical expenses once the $500 deductible has been met. Once the medical coinsurance out-of-pocket maximum has been met, HIRSP pays 100% of allowed costs for the remainder of the calendar year.

Annual family medical out-of-pocket maximums apply to family members who are on the same plan; the maximums are $4,000 for Plan 1, Option A; $7,000 for Plan 1, Option B, and $1,000 for Plan 2.

Drug Coinsurance and Out-of-Pocket Maximums

As of January 1, 2002, policyholders on all plans pay a drug coinsurance of 20% of the allowed amount for each prescription filled, up to a maximum of $25 for each prescription filled. Drug coinsurance out-of-pocket maximums vary by plan; Plan 1, Option A has a maximum of $750, Plan 1, Option B has a maximum of $1,000, and Plan 2 has a maximum of $125. Plan 1, Option A policyholders with qualifying income levels pay a reduced out-of-pocket maximum. Once the drug coinsurance out-of-pocket maximum has been met, HIRSP pays 100% of allowed prescription drug costs for the remainder of the calendar year.

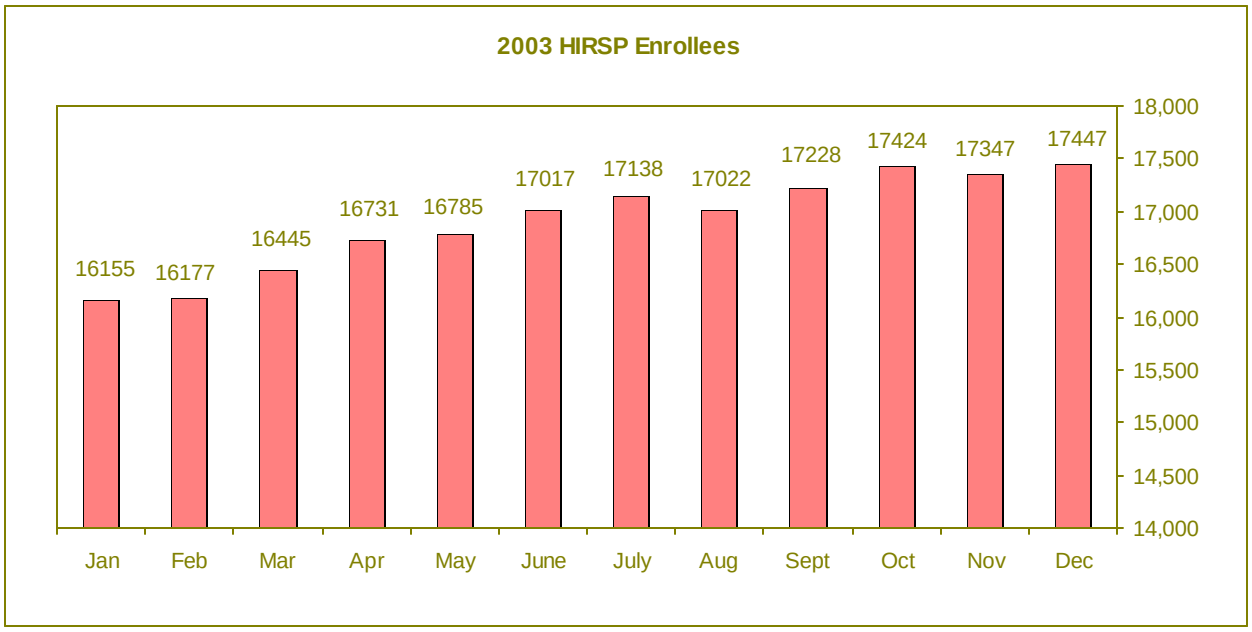
Lifetime Benefit Maximum

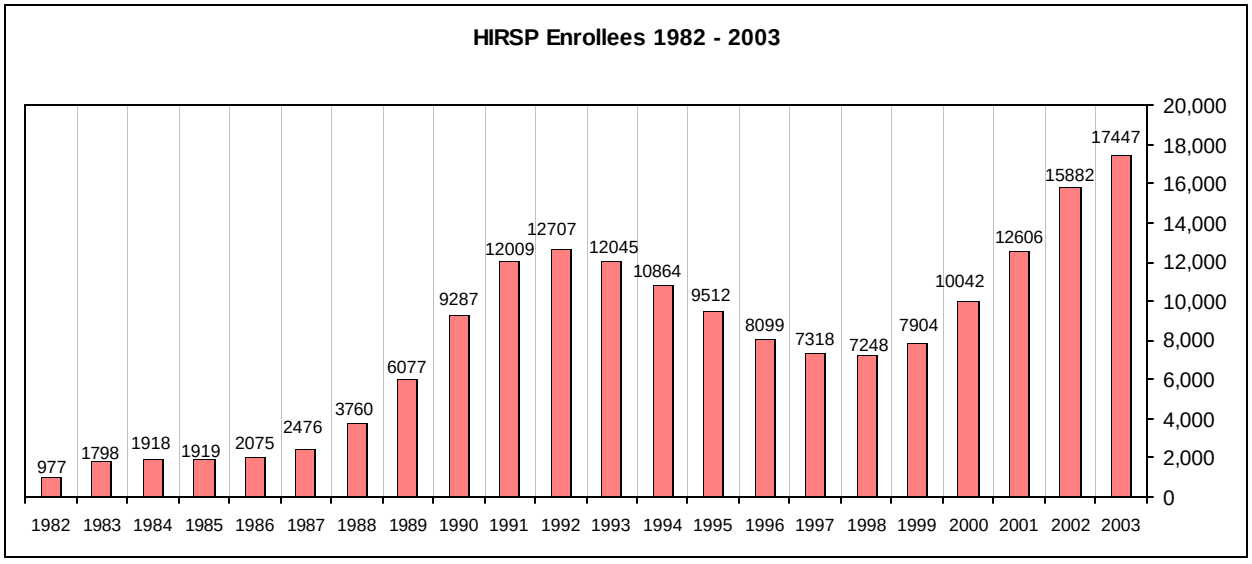
The lifetime benefit maximum for all HIRSP plans is $1,000,000. The benefit maximum is the total amount that can be paid out to a HIRSP enrollee over the course of his or her lifetime. It includes both medical and drug benefits.

Demographics

Enrollment

HIRSP' s enrollment increased 9.9% during 2003, from 15,882 in December 2002 to 17,447 in December 2003, a net increase of 1,565. This followed a trend of steadily increasing enrollments since 1998. The increase is also consistent with the enrollment growth experienced in other state-funded health care programs during the economic downturn.



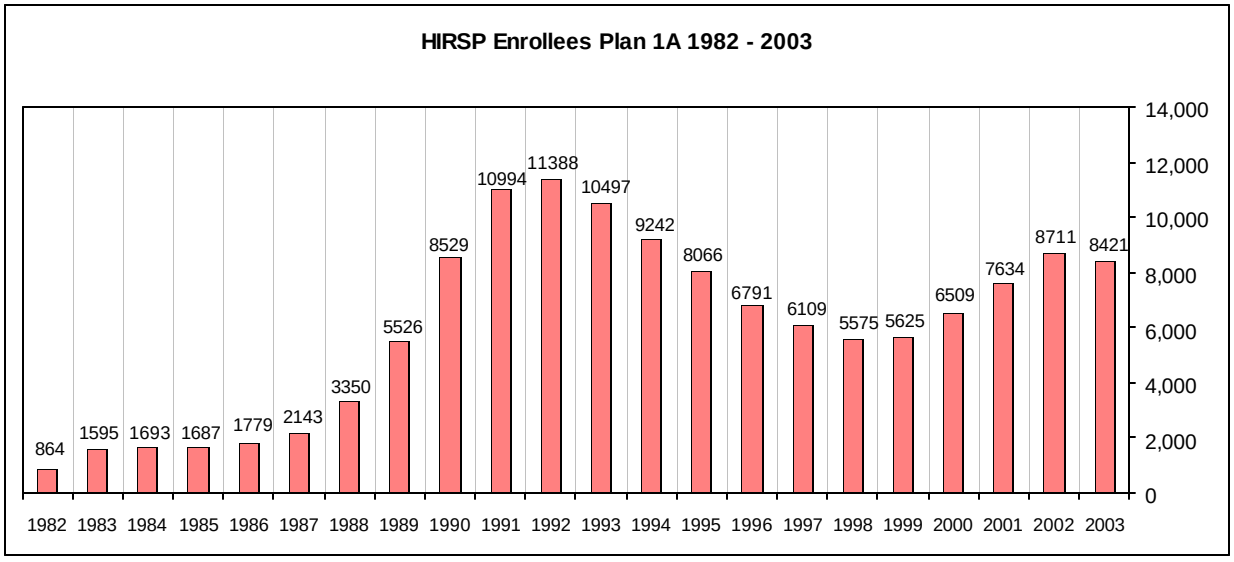


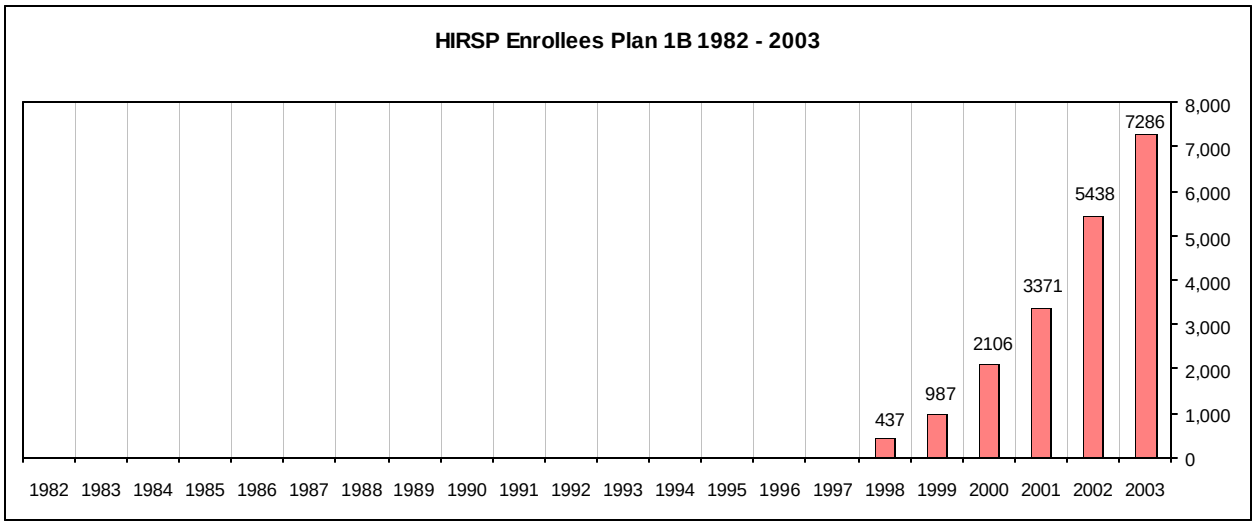
Enrollment by Plan

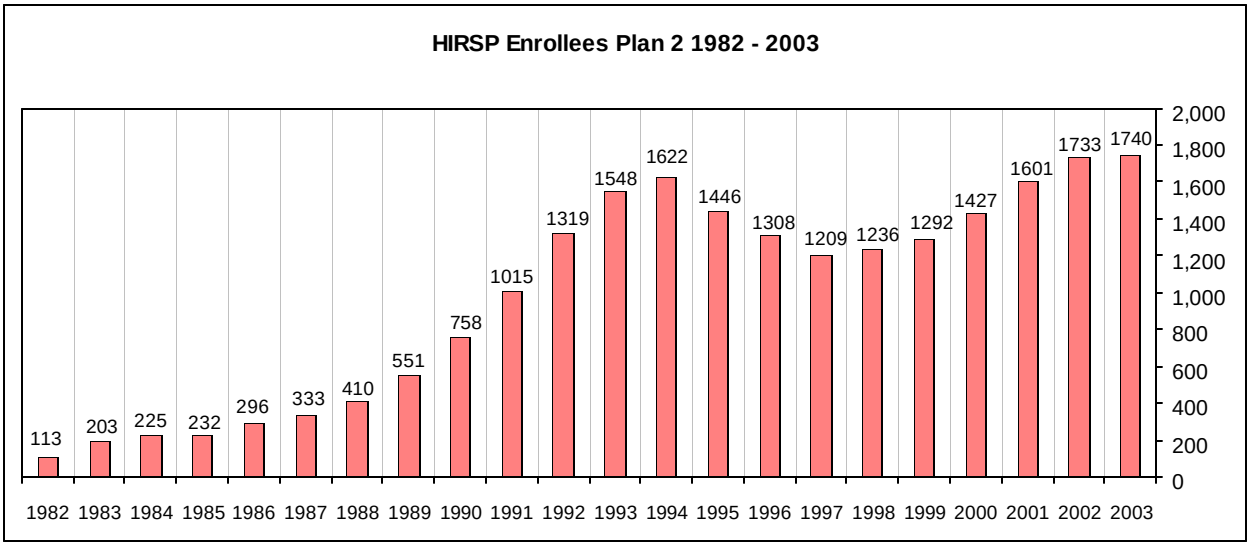
Enrollment in Plan 1, Options A and B, and Plan 2 shows that between 2002 and 2003:

- Plan 1, Option A enrollment decreased 3.3%, from 8,711 to 8,421.
- Plan 1, Option B, established in 1998, continued to experience the same large increases in enrollment during 2003 as was seen in prior years. Enrollment for this plan increased 34.0% from 5,438 to 7,286.
- Plan 2 enrollment remained constant in 2003, with enrollment changing from 1,733 to 1,740, a 0.4% increase.

HIRSP Policies in Force, 1982-2003, Calendar Year Basis







Choice of Coverage

The annual choice of coverage is offered to policyholders in the fall of each calendar year, offering them an opportunity to change between Plan 1A and Plan 1B during the annual choice of coverage period. The elected plan change becomes effective January 1 of the following calendar year.

Calendar year for which the change was effective	Plan 1A and 1B enrollment as of 12/31 of prior year[2]	Number of policyholders changing from 1A to 1B	Number of policyholders changing from 1B to 1A
1999	6,012	37	7
2000	6,612	267	24
2001	8,615	208	48
2002	11,005	350	75
2003	14,149	713	63
2004	15,707	440	72

[2] December Monthly Reports 1998-2003

Applications to HIRSP

In 2003, HIRSP experienced the first decline from the previous year in applications received with an average of 540 applications per month.[3] In the previous five years HIRSP applications had steadily increased. The following is the average number of applications received per month for each of the previous five years:

- 540 applications in 2003
- 597 applications in 2002
- 455 applications in 2001
- 420 applications in 2000
- 249 applications in 1999
- 180 applications in 1998

In 2003, rejection for health insurance coverage was the primary reason applicants sought and were approved for HIRSP coverage, accounting for 60% of the approvals. Qualifying under HIPAA as an eligible individual was the second most frequent reason for approval at 36.3%.

Application Statistics, 1999 – 2003								
Year	Received	Approved	Reason for approval					
			Medicare eligible	HIV+	HIPAA-eligible individual	Notice of Rejection	Notice of Benefit Reduction	Notice of Premium increase by 50%
2003 Total	6,479	5,616	126	29	2,036	3,372	48	5
2002 Total	7,163	6,454	192	27	2,031	4,125	60	19
2001 Total	5,455	5,093	212	38	1,795	2,946	77	25
2000 Total	5,043	4,069	145	31	1,831	1,982	54	26
1999 Total	2,985	2,254	112	33	740	1,303	52	14
2003 Monthly Average	540	468	11	2	170	281	4	<1
2002 Monthly Average	597	538	16	2	169	344	5	2
2001 Monthly Average	455	424	18	3	150	246	6	2
2000 Monthly Average	420	339	12	3	153	165	5	2
1999 Monthly Average	249	188	9	3	62	109	4	1
2003 Percent of Total Applications Approved			2.2%	0.5%	36.3%	60.0%	0.9%	0.1%
2002 Percent of Total Applications Approved			3.0%	0.4%	31.5%	63.9%	0.9%	0.3%
2001 Percent of Total Applications Approved			4.2%	0.7%	35.2%	57.8%	1.5%	0.5%
2000 Percent of Total Applications Approved			3.6%	0.8%	45.0%	48.7%	1.3%	0.6%
1999 Percent of Total Applications Approved			5.0%	1.5%	32.8%	57.8%	2.3%	0.6%

[3] HIRSP Monthly Reports 2003

The majority of HIRSP applicants who were approved for HIRSP coverage applied because they received a notice of rejection from an insurance carrier. The next chart lists the top ten insurance carriers that issued the greatest number of rejections resulting in applications to HIRSP in 2003.

Insurance Company Issuing Rejection	Resulting Applications to HIRSP
	2003 Total
Blue Cross and Blue Shield United of WI	746
Fortis	388
Golden Rule	386
WPS	351
Mega Life and Health	269
American Family	227
Humana	211
Security Health	108
AMS/American Medical Security	107
Midwest National	85

Refer to Appendix 8 of this report for the number of rejections issued by all insurers resulting in applications to HIRSP in 2002 and 2003.

Profile of HIRSP Policyholders

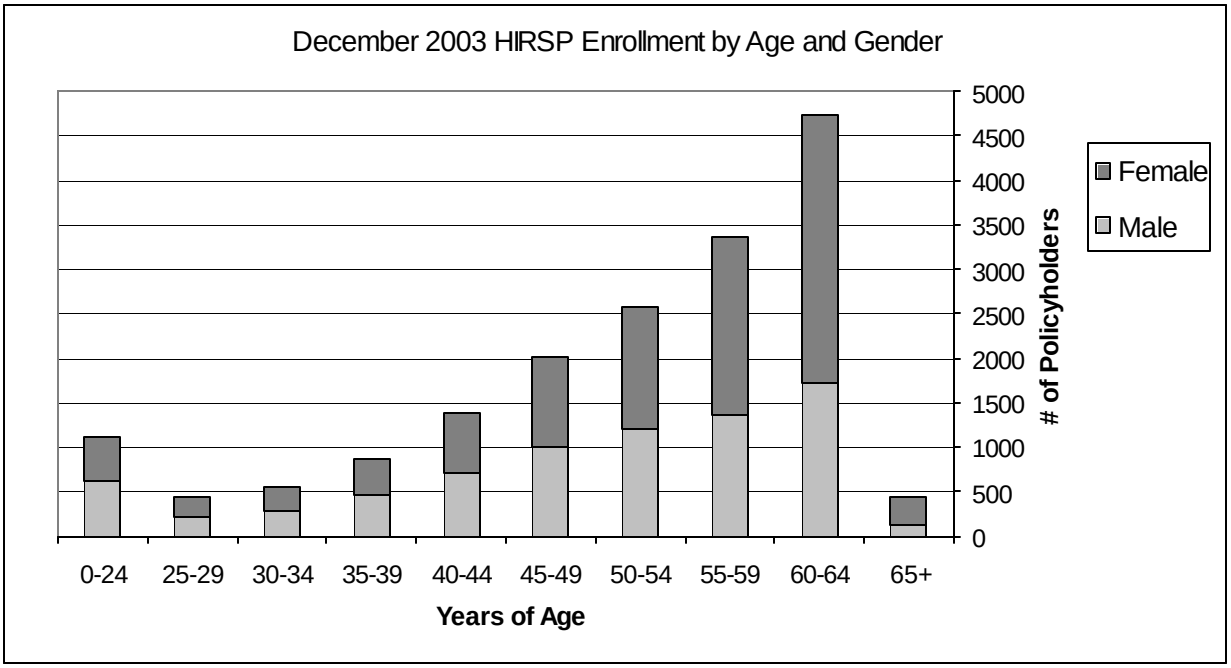
In 2003, HIRSP policyholders*, as a group, had the following characteristics:

Gender	56% were female, 44% male
Age	62% were between 50 and 64 years of age (female 37%; male 25%)
Employment	Unemployed – 49.3%; Self-employed – 26.3%; Fulltime – 21.1%; Part-time – 3.3% (based on application data)
Region	Zone 1 – 8%; Zone 2 – 29%; Zone 3 – 63%
Plan	Year end enrollment: Plan 1, Option A – 8,421; Plan 1, Option B – 7,286; Plan 2 – 1,740
Reason	60.9% were approved for HIRSP after receiving rejections or benefit reductions from an individual plan
Income	At least 77% of all policyholders had an income in excess of $25,000 based on the number of policyholders who apply or qualify for reduced premiums

* Based on enrollment as of 1/1/04 active policyholders with effective dates between 1/1/03 to 12/31/03.

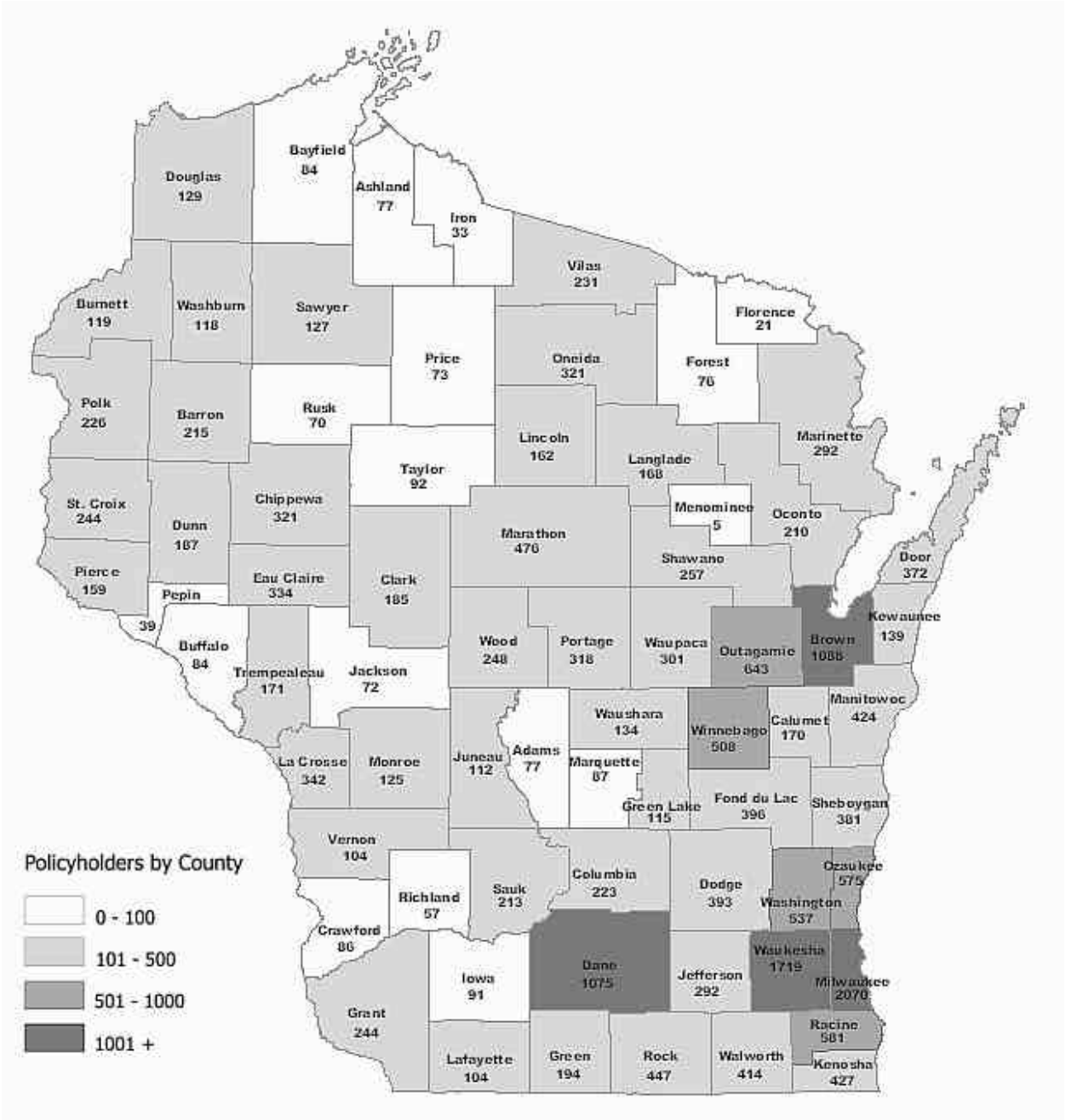
Age and Gender of Policyholders

Of the 17,447 policyholders enrolled in HIRSP at the end of 2003, the majority of female policyholders, 54%, were 55 years old or older. The majority of male policyholders, 57%, were 50 years old or older.



Geographic Distribution of Enrollees

HIRSP policyholders reside in every county in the state. The map represents the number of residents in each county who were covered by HIRSP at any time during the year 2003; therefore, the total number of policyholders indicated on the map will not reconcile with the 17,447 enrolled in December of 2003.



Length of Enrollment (Persistency)

The chart below shows the number of policyholders and the duration of their enrollment in the plan, as of December 31, 2003. The disproportionate number of policyholders enrolled four years or less corresponds to significant growth in enrollment for that time period.

Years	Male	Female	Total
Under 1	2,070	2,643	4,713
1 to 2	1,910	2,418	4,328
2 to 3	1,210	1,535	2,745
3 to 4	769	1,009	1,778
4 to 5	393	492	885
5 to 6	239	287	526
6 to 7	98	163	261
7 to 8	92	121	213
8 to 9	116	113	229
9 to 10	99	128	227
10 to 11	140	158	298
11 or more	561	683	1,244
Total	7,697	9,750	17,447

Policyholder Subsidies for Premiums and Deductibles

According to state law, policyholders in Plan 1, Option A are eligible for reduced premiums if their annual household income in the previous calendar year was less than $25,000 and are eligible for reduced deductibles and premiums if their annual household income in the previous calendar year was less than $20,000. Policyholders in Plan 1, Option B are not eligible for reductions. Policyholders in Plan 2 are eligible for reduced premiums if their household income in the previous calendar year was less than $25,000.

Subsidy Comparison															
	1999**			2000			2001			2002			2003		
Subsidy Level Income Range	Plan 1A	Plan 2	Total	Plan 1A	Plan 2	Total	Plan 1A	Plan 2	Total	Plan 1A	Plan 2	Total	Plan 1A	Plan 2	Total
Less than $10,000	834	155	989	876	157	1033	963	140	1103	1151	145	1296	1347	150	1497
$10,000 - $13,999	416	232	648	458	239	697	521	241	762	505	211	716	525	214	739
$14,000 - $16,999	324	145	469	384	144	528	337	168	505	400	186	586	418	168	586
$17,000 - $19,999	315	101	416	353	119	472	380	132	512	444	139	583	435	122	557
$20,000 - $24,999*	0	0	0	291	99	390	401	119	520	474	141	615	452	152	604
Total Subsidized Policyholders	1,889	633	2,522	2,362	758	3,120	2,602	800	3,402	2,974	822	3,796	3,177	806	3,983
Total Plan 1A and Plan 2 Policyholders at Year End	5,625	1,292	6,917	6,509	1,427	7,936	7,634	1,601	9,235	8,711	1,733	10,444	8,421	1,740	10,161
Percent Subsidized	34%	49%	36%	36%	53%	39%	34%	50%	37%	34%	47%	36%	38%	46%	39%

* This subsidy level was implemented 1/1/2000; category applies to reduced premiums only. Subsidy categories apply to Plan 1, Option A policyholders for reduced premiums and deductibles, and to Plan 2 policyholders for reduced premiums only.

** The number of subsidized policyholders matches the restated numbers of the May 2000 Monthly Report instead of the December 1999 Monthly Report. The level of detail shown here was not available until May 2000.

Although the number of subsidized policyholders in Plan 1, Option A and Plan 2 has gradually increased as a result of overall enrollment increases, the percent of subsidized policyholders has remained relatively constant, not more than 40% nor less than 35% over the last 5 years.

Funding

Funding Sources

In calendar year (CY) 2003, claims and administrative expenses were $131.4 million. State law currently stipulates three sources of funding for HIRSP:

- *Policyholder premium* : Premiums are to fund 60% of operating and administrative expenses. HIRSP premium rates differ based upon age, gender, and ZIP code zone of residence of the policyholder.

  Please refer to Appendix 4 of this report for details of methodology for calculating HIRSP premiums.

- *Insurer assessments:* Insurers are to pay 20% of HIRSP operating and administrative costs through assessments based on the health insurance premium volume each company writes for Wisconsin residents. Participating insurers share in the costs of HIRSP in proportion to their share of the total Wisconsin premium volume reported to the Wisconsin Office of the Commissioner of Insurance (OCI).

- *Provider discounts:* Health care providers are to pay 20% of HIRSP operating and administrative expenses through reductions in HIRSP claim payments.

Prior to July 1, 2003, the Wisconsin Legislature set an amount of GPR in each biennial budget to offset plan costs. In CY 2003, $4.75 million of GPR was appropriated for HIRSP. The FY 2004 budget does not include an appropriation of GPR to fund plan expenses.

In prior years, in addition to these funding sources, a separate State GPR appropriation provided funds to reduce premiums in Plan 1, Option A and Plan 2 for policyholders whose annual household incomes are less than $25,000. Reductions in medical deductibles and drug coinsurance out of pocket maximums are also available for Plan 1, Option A policyholders whose annual household incomes are less than $20,000. According to state law, policyholders enrolled in Plan 1, Option B are not eligible for reductions of premiums or deductibles.

In 2003, there was no GPR appropriation to fund the subsidy reductions. Insurers and providers were required to fund the balance in equal shares. The total cost of reductions (subsidies) in 2003 was $4,914,091. These costs were split between insurers and providers, leaving insurers to cover $2,457,043, and providers to cover $2,457,048.

The Department and the Board of Governors reconcile plan costs and revenues each year to ensure that policyholder premiums, including credits for premium and deductible subsidy amounts, insurer assessments, and provider discounts meet the levels required by law.

Financial Information

This section of the HIRSP annual report contains general financial information about HIRSP. Please refer to Appendices 5-7 of this report for details.

Costs and Funding

The Department and the Board of Governors, supported by actuarial consultants, oversee all financial matters relating to HIRSP, including, but not limited to, approval of premium rates, insurance industry assessments, and adjustments to provider payment rates to assure compliance with statutes. In addition, they develop the annual operating budget and perform calendar year reconciliations.

The Legislative Audit Bureau has audited HIRSP' s financial statements every year since 1998.

Overall Plan Costs

HIRSP administrative costs increased by 21.8% in 2003 compared to 2002, while the overall plan costs increased by 25.0%, resulting in an overall decrease in the administrative costs in relation to overall costs. The percentage of administrative costs to total plan costs has consistently declined since 2000. Administrative costs of $5,148,407 in 2003 represented 3.9% of the total plan costs of $131,358,386. Claims incurred and subsidy costs of the plan have risen with enrollment and utilization to represent 96.1% of total plan costs. Refer to Appendix 5 of this report for details of the CY 2003 reconciliation of plan costs.

Overall Plan Costs[4]

	CY 1999	CY 2000	CY 2001	CY 2002	CY 2003
Total plan costs	$50,107,757	$54,451,356	$76,451,816	$105,111,061	$131,358,386
Administrative costs *	$3,287,510	$3,842,068	$4,480,073	$4,226,531	$5,148,407
Administrative as % of total	6.6%	7.1%	5.9%	4.0%	3.9%

* Includes DHFS, EDS and UGS Administrative costs, Milliman Actuarial costs and referral fees

[4] Calendar Year Reconciliation.

Policyholder 60%

HIRSP premium rates were set at 140% of standard rates in 2003, which was the lowest level permitted by law at the time the premiums were established. When premiums fund more than 60% of plan costs, excess premium revenues accrue. As required by law, the DHFS has set aside excess premium revenue, the use of which is restricted by state law for the following uses:

- Reducing policyholder premiums if above 140% in future years.
- Other uses as approved by the board of governors.

Insurer 20%

In 2003, state law required insurers to fund 20% of total HIRSP costs and 50% of the amount of reductions in premiums and/or deductibles and drug coinsurance that exceeded the GPR appropriation for reductions. Assessments are adjusted each year to maintain compliance with this requirement.

Provider 20%

In 2003, providers that participated in HIRSP (with the exception of pharmacy providers) were also required by state law to fund 20% of total HIRSP costs and 50% of the amount of reductions in premiums and/or deductibles and drug coinsurance that exceeded the GPR appropriation for reductions. Providers contributed their required portion of HIRSP funding through discounted payments of claims.

Claims to Premiums Loss Ratio

The claims to premiums loss ratio reflects the relationship of incurred claims to earned premiums for all policyholders. A loss ratio over 100% indicates that the plan is paying out more in claims than it collects in premiums, and conversely, a loss ratio under 100% indicates that the plan is collecting more in premiums (including premium subsidies funded by insurers, providers and state GPR) than it is paying out in claims. HIRSP' s overall loss ratio for 2003 was 162.7%[5]. An adverse loss ratio of this magnitude would be unsustainable without the high level of deficit non-premium funding provided by insurers, providers, and state GPR.

Earned premium for 2003 is the amount of premiums billed to and paid by policyholders plus the amounts for premium reductions funded by other payers for coverage between January 1, 2003, and December 31, 2003. For example, premiums paid in December 2002, for first quarter 2003 coverage, are included in CY 2003 earned premiums for coverage January 1, 2003, through March 31, 2003.

Incurred claims include: 1) the gross cost of services performed in CY 2003 and paid in CY 2003; and 2) the estimated cost of services performed in CY 2003, to be paid in CY 2004 and later.

[5] Milliman

CY03 Claims to Premiums Loss Ratio[6]					
	Total Dollars			Per Member Per Month	
Plan	Incurred Claims	Earned Premiums	Loss Ratio	Incurred Claims	Earned Premiums
Plan 1, Option A	$79,588,218	$41,173,816	193.3%	$786.04	$406.65
Plan 1, Option B	$30,292,631	$28,709,651	105.5%	$369.50	$350.19
Plan 2	$16,306,478	$7,681,826	121.3%	$782.99	$368.86
Total	$126,187,327	$77,565,293	162.7%	$618.38	$380.11

Note: Loss ratio = incurred claims ÷ earned premiums.
Earned premiums include premium subsidies.
Incurred claims are stated prior to application of provider rate reductions.
Administrative expenses are not included in this exhibit.
Incurred claims and earned premiums are updated quarterly and restated to reflect the most current information available as of March 31, 2004.

HIRSP Funding Shares and Cost Sharing

The unprecedented recent growth in average HIRSP enrollment, (21% in 2000, 28% in 2001, 26% in 2002, and 15% in 2003) has been accompanied by a corresponding growth in HIRSP costs. Between 1999 and 2003 HIRSP' s average enrollment increased by 125% from 7,561 to 17,005. Over the same period, program costs have increased by 162% (from $50 million in 1999 to $131 million in 2003).

State GPR Funding Share

State general purpose revenue (GPR) funding for HIRSP costs was not tied to growth in HIRSP program costs (as are policyholder, insurer, and provider funding shares), but was set as a sum certain appropriation in the state budget. The state GPR funding share for HIRSP was $11.7 million in 1999, 2000 and 2001, was reduced to $10.5 million in 2002, and then eliminated in the SFY 2003 state budget. As of July 1, 2003, state GPR funding has ceased, leaving policyholders, providers, and insurers to provide 100% of the program costs. State GPR funding represented 23% of total HIRSP program costs in 1999, and declined to 21% in 2000, to 15% in 2001, to 10% in 2002, and covering only 4% of the program costs in 2003. State GPR funding for HIRSP steadily declined since 1998 as a percent of total HIRSP program costs, and has ended completely effective July 1, 2003. Increases in HIRSP costs must be absorbed by policyholders, insurers, and providers.

Policyholder Funding Share

The amount of the HIRSP policyholder funding share increased from $54,679,800 in 2002 to $72,738,615 in 2003, an increase of 33%. The majority of this increase was due to increasing enrollment. The actual increase in the policyholder-funding share was 16% per policyholder over

[6] Milliman

the past year (from an average of $3,701 in 2002 to an average of $4,277 in 2003). However, the actual policyholder premium increase was tied to the increase in the industry standard rate as required by law.

Provider Funding Share

The required provider funding has increased from $19,966,426 in 2002 to $26,934,885 in 2003, an increase of 35%. The majority of this increase was due to increasing enrollment and the decline of GPR appropriations for HIRSP funding. Provider funding is generated by rate reductions on claims processed and paid (excluding prescription drug claims).

Insurer Funding Share

The required insurer funding has increased from $19,966,420 in 2002 to $26,934,890 in 2003, an increase of 35%. The majority of this increase was due to increasing enrollment and the decline of GPR appropriations for HIRSP funding. The amount each Wisconsin health insurer is assessed is based on the individual insurer' s market share of Wisconsin health insurance business.

How Total HIRSP Costs Are Distributed

Appendix 7 provides additional detail regarding state GPR, policyholder, insurer and provider funding shares from 1999-2003. As Appendix 7 shows, the amount of plan costs paid by non-HIRSP policyholders was $50.4 million in 2002 and increased to $58.6 million in 2003, an increase of 16%. The percent of plan costs paid by non-HIRSP policyholders was 50.6% in 2001, 48.0% in 2002, and continued to decrease in 2003 to 44.6%. Under statutes in effect in 2003, the percent of plan costs paid by non-HIRSP policyholders was made up by insurer assessments and provider contributions as explained above as well as GPR funding for the first half of CY 2003.

Utilization and Costs

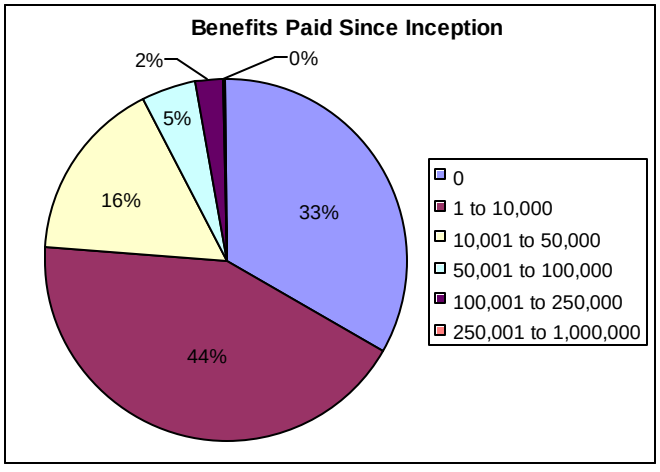
Calendar Year and Lifetime Benefit Use

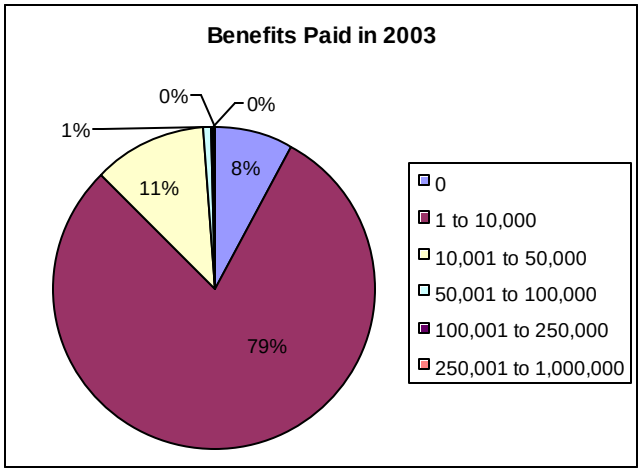
The following charts illustrate HIRSP benefit usage during CY 2003 and since the plan' s inception. In CY 2003, HIRSP paid over $50,000 in benefits for 224 individual policyholders, and $10,000 or less for 16,576 individual policyholders.

Benefit dollars paid represents the amount HIRSP paid on claims after all applicable deductible and coinsurance amounts have been subtracted.

Benefit Dollars Paid	Number of Policyholders		
	Since Inception	In 2003*	In 2002
0	13,087	1,528	1,431
1 to 10,000	16,789	15,048	12,811
10,001 to 50,000	6,473	2,135	1,876
50,001 to 100,000	1,891	189	167
100,001 to 250,000	931	33	40
250,001 to 1,000,000	133	2	1

* This column includes policyholder benefits (Medical and Pharmacy) paid in 2003 with dates of service in 2003 and prior. Accordingly, the total number of policyholders identified in this column will not reconcile with the total number of policyholders active in HIRSP during 2003. Since this table includes service dates prior to 2003, this table cannot be utilized to quantify the number of active policyholders meeting their deductibles in 2003. Please refer to the charts on page 24 that outline the number of policyholders meeting their deductibles in 2003.





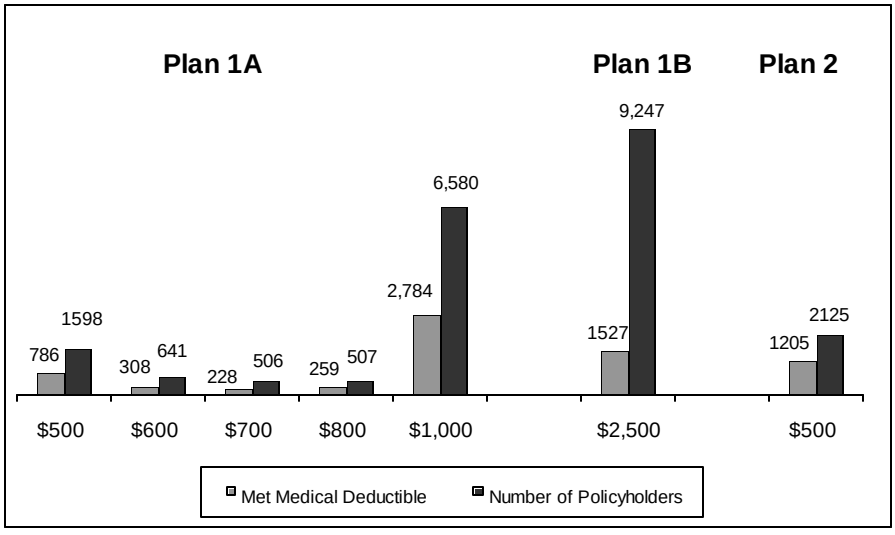
Policyholders Who Met Their Deductible

The number of policyholders who met their medical deductible increased from 30% in 2002 to 33% in 2003.

The following charts show, by plan, the number of HIRSP policyholders who met separate annual medical deductibles and pharmacy out-of-pocket maximums for services provided in 2003. The tables below represent policyholders enrolled at any time during CY 2003; therefore, the total number of policyholders indicated in the table will not reconcile with the 17,447 enrolled as of December 31, 2003.

Pharmacy Out-of-Pocket Max Met By HIRSP Policyholders Eligible At Any Time In 2003								
	Plan 1A					Plan 1B	Plan 2	TOTAL
Pharmacy Out of Pocket Max	$375	$450	$525	$600	$750	$1,000	$125	N/A
Percent of policyholders meeting pharmacy out of pocket max	22%	23%	19%	14%	11%	0.7%	74%	14%
Number meeting pharmacy out of pocket max	355	149	98	72	712	63	1,582	3,031
Number of policyholders	1,598	641	506	507	6,580	9,247	2,125	21,204

Medical Deductible Met By HIRSP Policyholders Eligible At Any Time In 2003								
	Plan 1A					Plan 1B	Plan 2	TOTAL
Medical Deductible Amount	$500	$600	$700	$800	$1,000	$2,500	$500	N/A
Percent of policyholders meeting medical deductible	49%	48%	45%	51%	42%	17%	57%	33%
Number meeting medical deductible	786	308	228	259	2,784	1,527	1,205	7,097
Number of policyholders	1,598	641	506	507	6,580	9,247	2,125	21,204

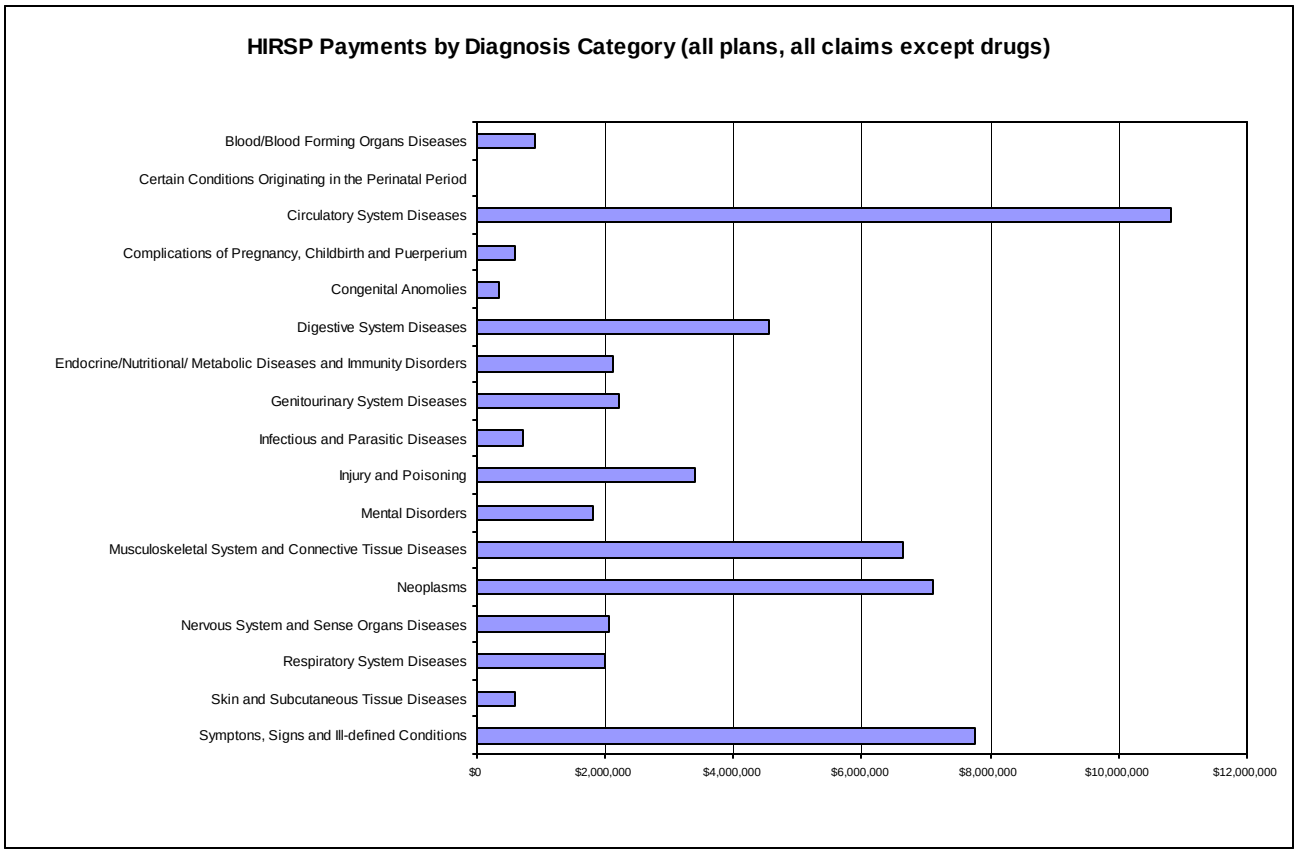


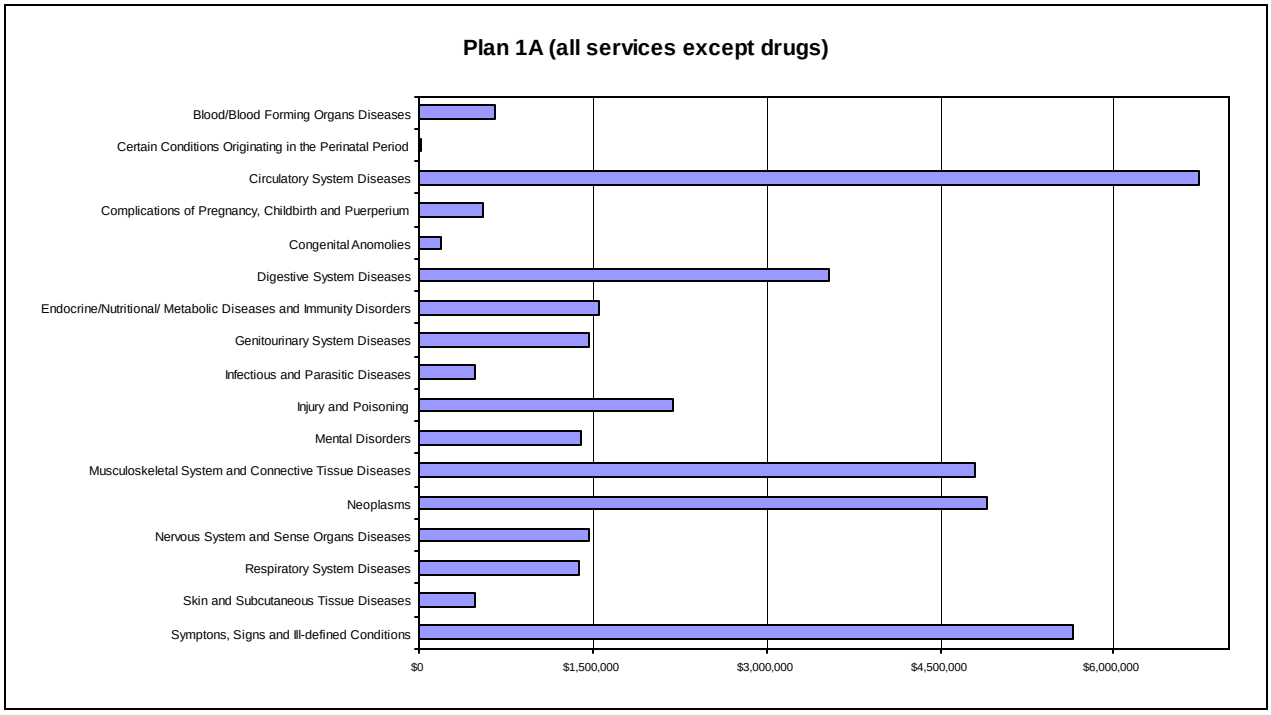
Diagnosis Categories

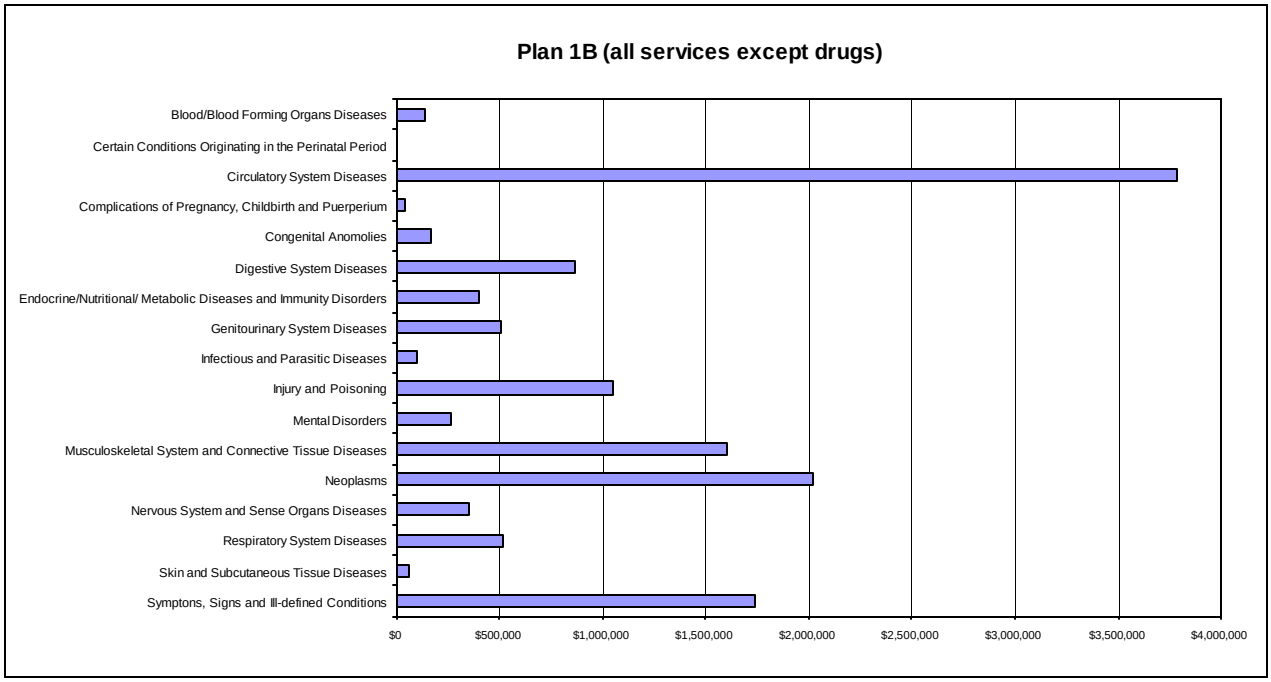
The charts that follow present diagnosis categories for claim dollars (excluding prescription drugs) spent in 2003. The diagnosis categories shown depict diagnoses used on individual claims and do not necessarily represent primary diagnoses of HIRSP policyholders.

Consistent with 2001 and 2002, HIRSP' s most costly disease classification in 2003 was Circulatory System Diseases. This disease classification includes such conditions as stroke, heart disease, hypertensive disease, and pulmonary circulation disease. Other than ill-defined conditions, Neoplasm is the second most costly diagnosis category, although far less costly than Circulatory System Diseases.

Note: The cost scale that runs across the bottom of each chart is different for each plan. The costs reflect dollars paid by the program and do not include deductibles, coinsurance, or provider contributions.




Plan 1A (all services except drugs)
Blood/Blood Forming Organs Diseases
Certain Conditions Originating in the Perinatal Period
Circulatory System Diseases
Complications of Pregnancy, Childbirth and Puerperium
Congenital Anomolies
Digestive System Diseases
Endocrine/Nutritional/ Metabolic Diseases and Immunity Disorders
Genitourinary System Diseases
Infectious and Parasitic Diseases
Injury and Poisoning
Mental Disorders
Musculoskeletal System and Connective Tissue Diseases
Neoplasms
Nervous System and Sense Organs Diseases
Respiratory System Diseases
Skin and Subcutaneous Tissue Diseases
Symptons, Signs and Ill-defined Conditions
$0
$1,500,000
$3,000,000
$4,500,000
$6,000,000


Plan 1B (all services except drugs)
Blood/Blood Forming Organs Diseases
Certain Conditions Originating in the Perinatal Period
Circulatory System Diseases
Complications of Pregnancy, Childbirth and Puerperium
Congenital Anomolies
Digestive System Diseases
Endocrine/Nutritional/ Metabolic Diseases and Immunity Disorders
Genitourinary System Diseases
Infectious and Parasitic Diseases
Injury and Poisoning
Mental Disorders
Musculoskeletal System and Connective Tissue Diseases
Neoplasms
Nervous System and Sense Organs Diseases
Respiratory System Diseases
Skin and Subcutaneous Tissue Diseases
Symptons, Signs and Ill-defined Conditions
$0
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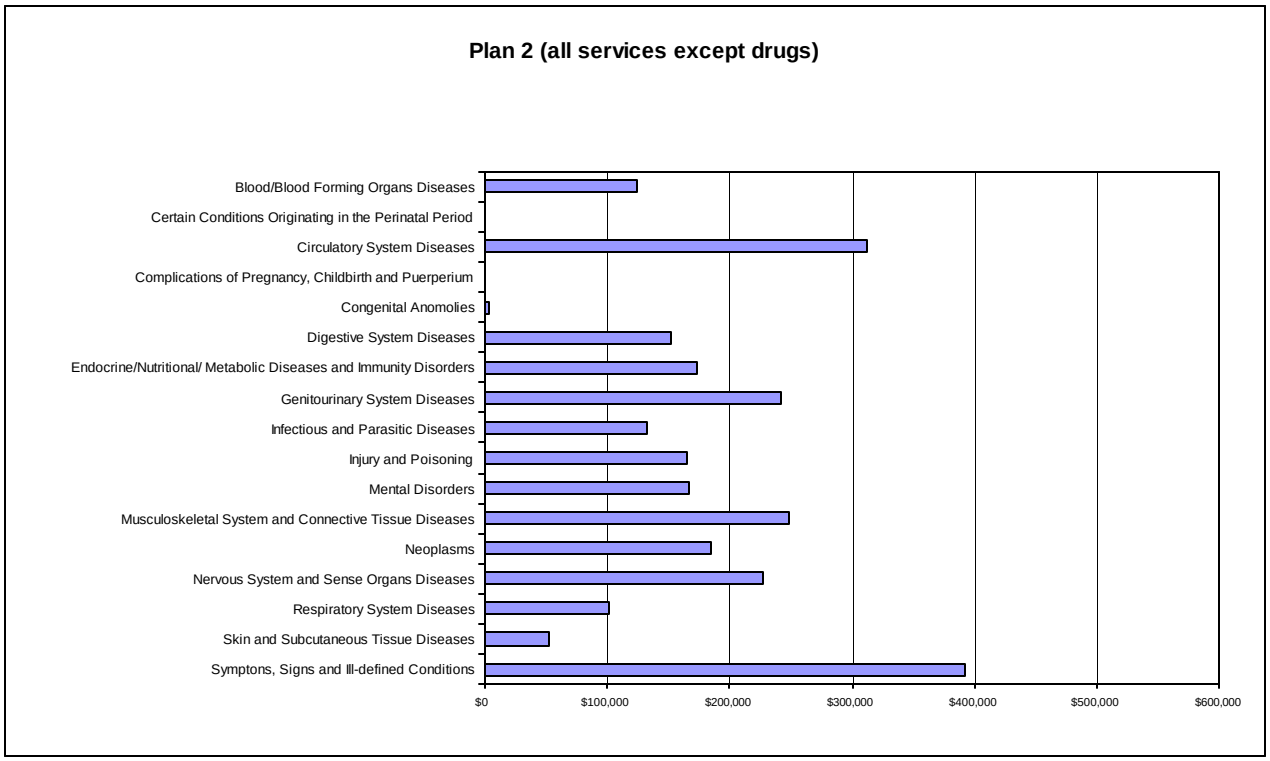
$4,000,000

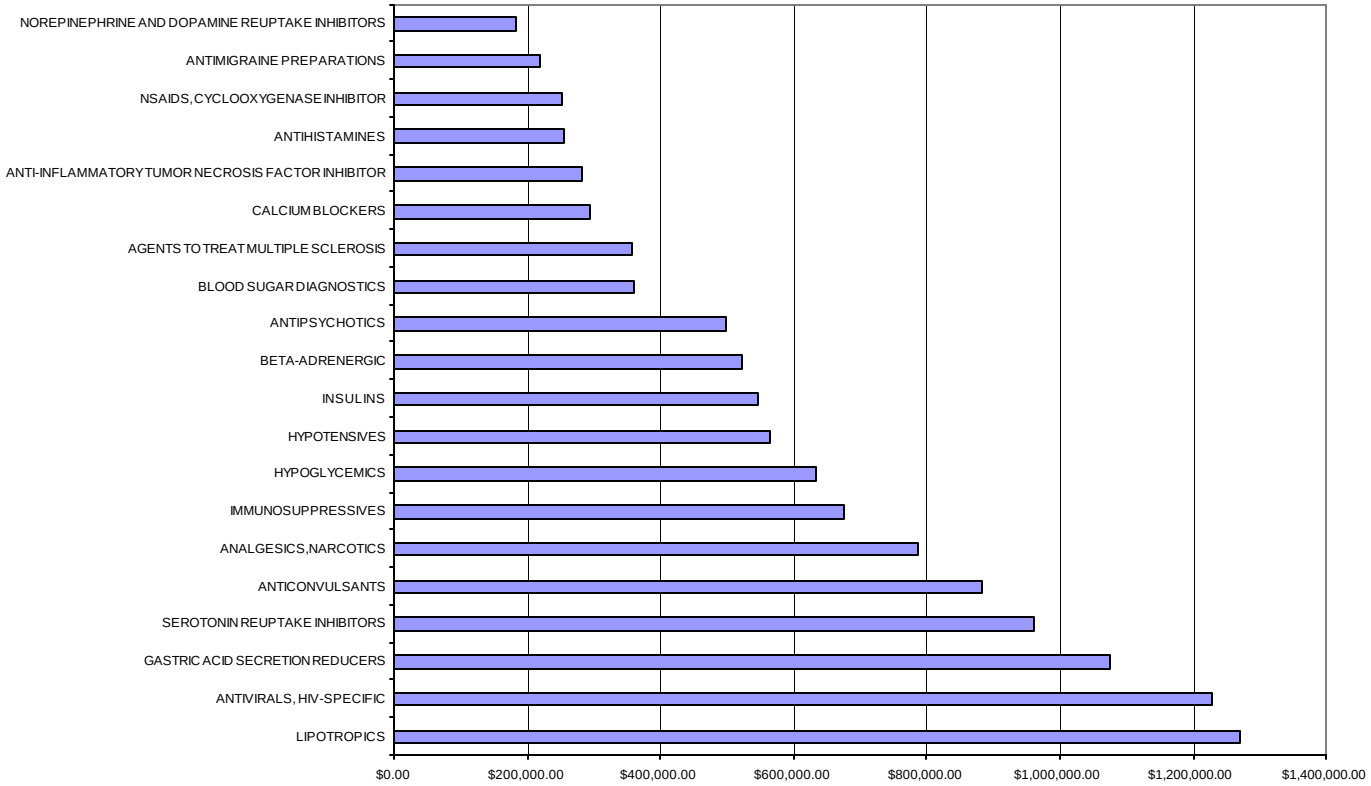


Drug Costs

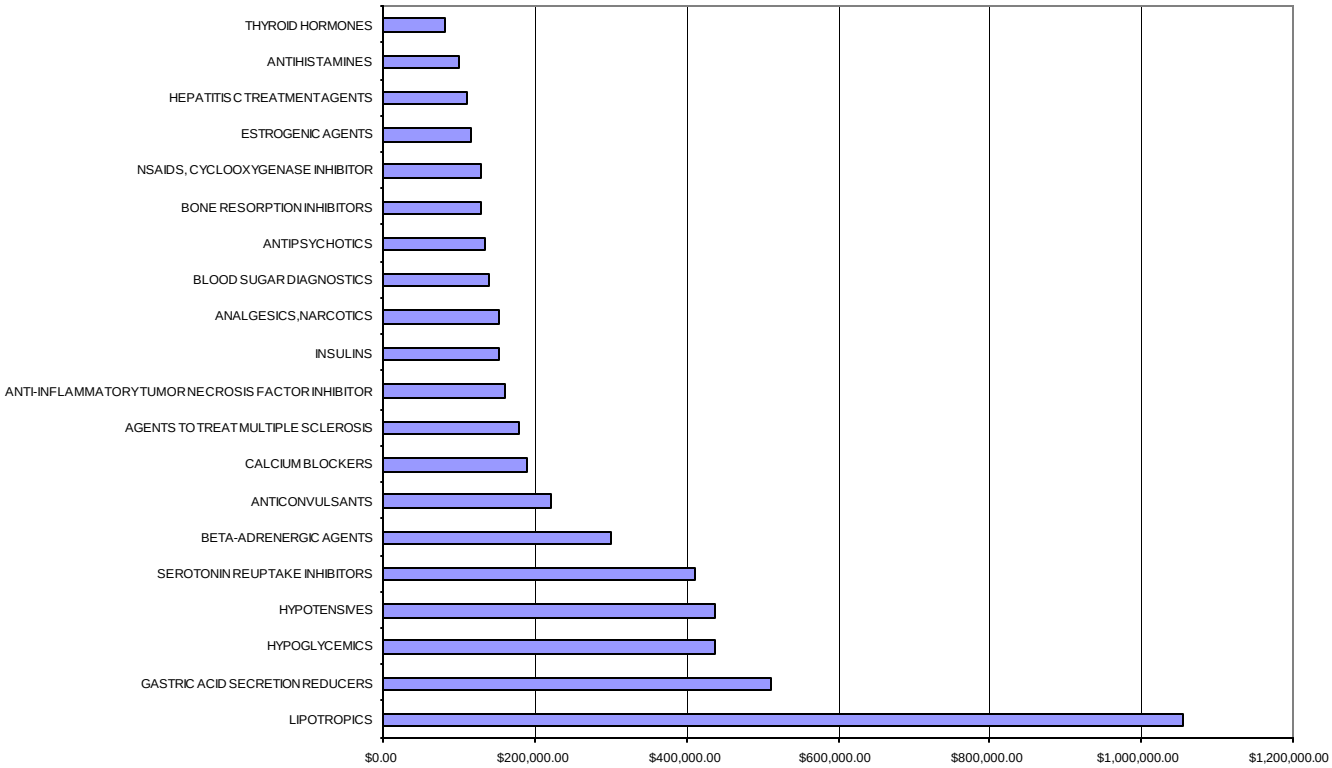
During CY 2003, 591,862 prescriptions were filled and $36.3 million was paid for prescription drugs for HIRSP policyholders. The breakdown by plan: Plan 1, Option A, $17.4 million; Plan 1, Option B, $6.5 million; and Plan 2, $12.4 million. Costs for Lipotropics far outweighed costs for any other therapeutic classification for participants in Plan 1, Option A. This trend also carried through for Plan 1, Option B. HIV-Specific Antivirals represented the largest portion of drug expenditures for Plan 2.

The following charts show the top 20 drug expenditures by Specific Therapeutic Classification paid for by each of the three HIRSP plans.

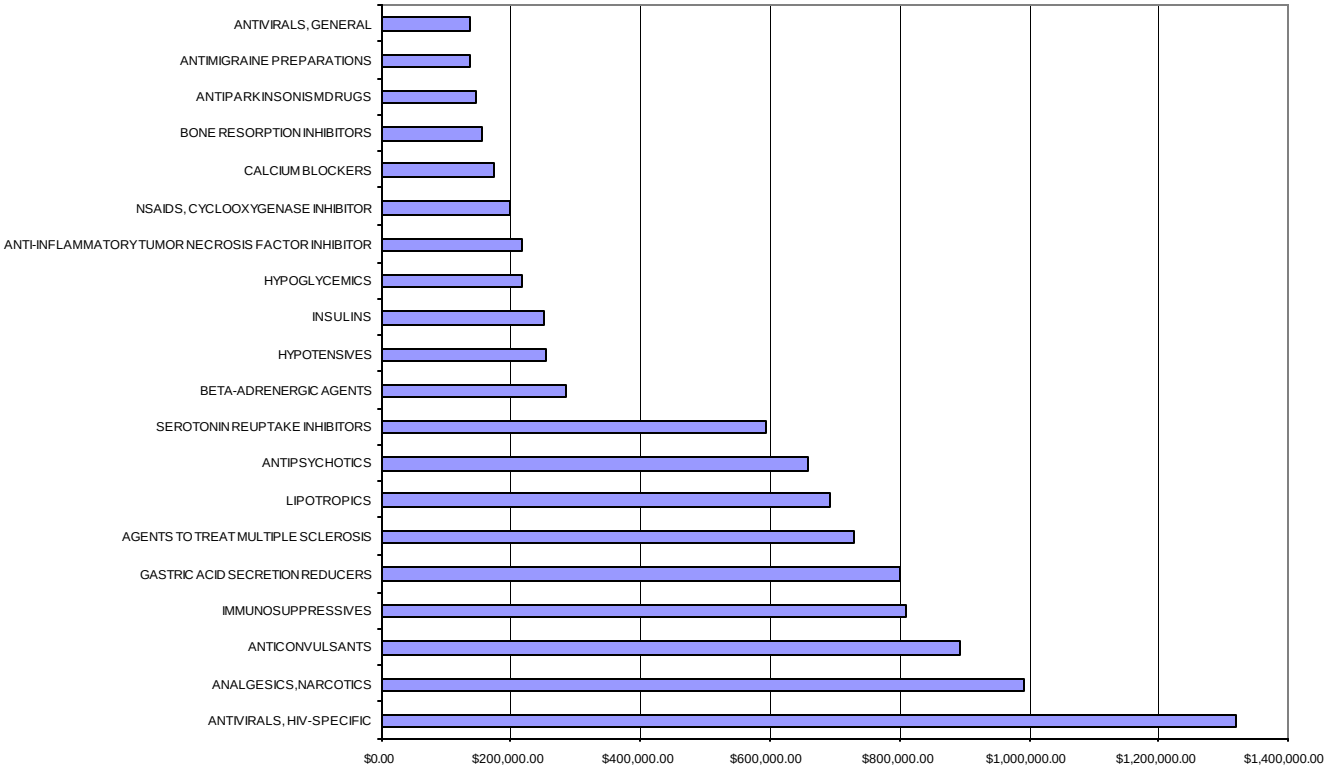
Plan1A, Top 20 Drug Expenditures by Specific Therapeutic Drug Classification



Plan1B, Top 20 Drug Expenditures by Specific Therapeutic Drug Classification



Plan 2, Top 20 Drug Expenditures by Specific Therapeutic Drug Classification



Appendix 1

HIRSP Board of Governors
Membership Roster

Current Members	Organization Represented
Mark Moody, Chair Wisconsin Department of Health and Family Services (DHFS)	DHFS Secretary, or a designated representative for the DHFS
Toni Burton Independence First	Public Member
Bill Felsing United Healthcare of Wisconsin, Inc.	Participating Insurer
Dianne Greenley Wisconsin Coalition for Advocacy	Public Member
Claire Johnson Group Health Cooperative of Eau Claire	Participating Insurer, Nonprofit
Michelle Bachhuber, M.D. Marshfield Clinic C/O Preoperative and Health Screening Unit	State Medical Society of Wisconsin
Eileen Mallow Office of the Commissioner of Insurance (OCI)	The Commissioner of Insurance, or a designated representative for OCI
Joe Kachelski Wisconsin Health and Hospital Association	Wisconsin Health and Hospital Association
Bill Smith National Federation of Independent Business, WI	Public Member (Representative of small businesses)
Annette Stebbins	Public Member (HIRSP Policyholder)
Robert Wood Wisconsin Physicians Service Insurance Corporation	Participating Insurer, Nonprofit
Larry Zanoni Group Health Cooperative of South Central Wisconsin	Participating Insurer
Paul Nannis Aurora Health Care	Integrated Multidisciplinary Health System

Appendix 2

Eligibility Requirements

HIRSP' s eligibility requirements are set forth in s. 149.12, Wisconsin Statutes. To be eligible for HIRSP, applicants must meet all the requirements set forth under *General Requirements*, below. In addition, applicants must also meet either the requirements under *Eligibility Based on Medical Condition* or the requirements in the *Eligibility Based on Lost Employer-Sponsored Group Health Insurance*, following.

General Requirements

All applicants to HIRSP must meet the following requirements:

- Are residents of Wisconsin.
- Are not eligible for employer-sponsored group health insurance.
- Are not eligible for Wisconsin Medicaid or BadgerCare.
- Meet the requirements described under one of the following two sections.

Eligibility Based on Medical Condition

Those applicants who are younger than age 65 and meet the *General Requirements* noted in the previous section are eligible for HIRSP if they meet *at least one* of the following requirements:

- Are eligible for Medicare because of a disability.
- Have tested positive for the Human Immunodeficiency Virus (HIV).
- In the past nine months, have received a notice of rejection, cancellation, significant reduction of coverage, or increases in premiums of 50% or more from one or more health insurers based on a mental or physical condition.

Eligibility Based on Lost Employer-Sponsored Group Health Insurance

Those applicants who meet the *General Requirements* in the section above are eligible for HIRSP if they meet *all* of the following requirements:

- HIRSP received the completed application within 63 days of the date the employer-sponsored group health insurance was lost.
- Have not voluntarily cancelled coverage.
- Have had continuous insurance coverage for at least 18 months with no gap in coverage greater than 63 days.
- Have exhausted continuation coverage under the employer-sponsored group health insurance, including state continuation coverage or Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage.
- Most recent period of health insurance coverage was under employer-sponsored group health insurance.
- Are not eligible for Medicare.

Appendix 3

HIRSP 2003 Annual Full Premium Rate Tables Effective Date: July 1, 2003

Plan 1, Option A/Male ($1,000 Deductible)			
	Zone		
Age Bracket	1	2	3
0-24	$2,232.00	$2,016.00	$1,800.00
25-29	$2,340.00	$2,100.00	$1,860.00
30-34	$2,640.00	$2,388.00	$2,112.00
35-39	$3,072.00	$2,556.00	$2,472.00
40-44	$3,660.00	$3,288.00	$2,928.00
45-49	$4,716.00	$4,248.00	$3,780.00
50-54	$6,312.00	$5,676.00	$5,052.00
55-59	$8,364.00	$7,524.00	$6,684.00
60-64	$10,836.00	$9,744.00	$8,664.00
65+	$10,836.00	$9,744.00	$8,664.00

Plan 1, Option A/Female ($1,000 Deductible)			
	Zone		
Age Bracket	1	2	3
0-18	$2,232.00	$2,016.00	$1,800.00
19-24	$2,844.00	$2,556.00	$2,268.00
25-29	$3,192.00	$2,868.00	$2,556.00
30-34	$3,528.00	$3,180.00	$2,820.00
35-39	$4,032.00	$3,624.00	$3,228.00
40-44	$4,584.00	$4,128.00	$3,684.00
45-49	$5,412.00	$4,872.00	$4,332.00
50-54	$6,480.00	$5,832.00	$5,196.00
55-59	$7,560.00	$6,804.00	$6,048.00
60-64	$8,904.00	$8,016.00	$7,128.00
65+	$8,904.00	$8,016.00	$7,128.00

Plan 1, Option B/Male ($2,500 Deductible)			
	Zone		
Age Bracket	1	2	3
0-24	$1,608.00	$1,452.00	$1,296.00
25-29	$1,680.00	$1,512.00	$1,344.00
30-34	$1,896.00	$1,716.00	$1,524.00
35-39	$2,208.00	$1,992.00	$1,776.00
40-44	$2,640.00	$2,364.00	$2,112.00
45-49	$3,396.00	$3,060.00	$2,724.00
50-54	$4,548.00	$4,092.00	$3,636.00
55-59	$6,024.00	$5,412.00	$4,812.00
60-64	$7,800.00	$7,020.00	$6,240.00
65+	$7,800.00	$7,020.00	$6,240.00

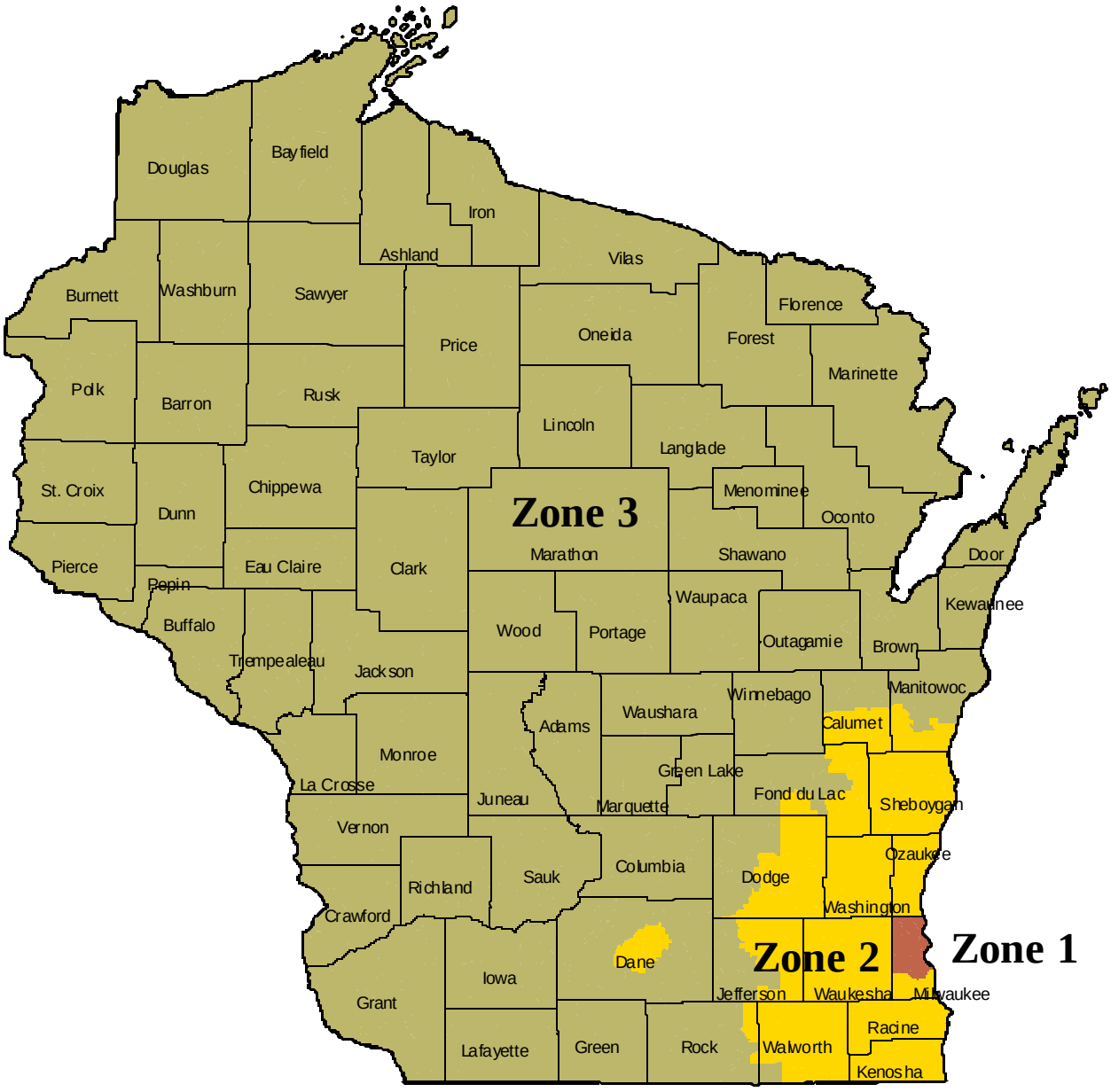
Plan 1, Option B/Female ($2,500 Deductible)			
	Zone		
Age Bracket	1	2	3
0-18	$1,608.00	$1,452.00	$1,296.00
19-24	$2,052.00	$1,836.00	$1,632.00
25-29	$2,304.00	$2,064.00	$1,836.00
30-34	$2,544.00	$2,292.00	$2,028.00
35-39	$2,904.00	$2,604.00	$2,328.00
40-44	$3,300.00	$2,976.00	$2,652.00
45-49	$3,900.00	$3,504.00	$3,120.00
50-54	$4,668.00	$4,200.00	$3,744.00
55-59	$5,448.00	$4,896.00	$4,356.00
60-64	$6,408.00	$5,772.00	$5,136.00
65+	$6,408.00	$5,772.00	$5,136.00

Plan 2/Male ($500 Deductible)			
	Zone		
Age Bracket	1	2	3
0-24	$1,716.00	$1,548.00	$1,380.00
25-29	$1,776.00	$1,608.00	$1,428.00
30-34	$2,016.00	$1,836.00	$1,608.00
35-39	$2,352.00	$2,112.00	$1,884.00
40-44	$2,808.00	$2,520.00	$2,232.00
45-49	$3,612.00	$3,240.00	$2,892.00
50-54	$4,824.00	$4,332.00	$3,864.00
55-59	$6,396.00	$5,748.00	$5,112.00
60-64	$8,280.00	$7,440.00	$6,624.00
65+	$8,280.00	$7,440.00	$6,624.00

Plan 2/Female ($500 Deductible)			
	Zone		
Age Bracket	1	2	3
0-18	$1,716.00	$1,548.00	$1,380.00
19-24	$2,172.00	$1,944.00	$1,728.00
25-29	$2,436.00	$2,196.00	$1,944.00
30-34	$2,700.00	$2,424.00	$2,148.00
35-39	$3,072.00	$2,772.00	$2,472.00
40-44	$3,516.00	$3,156.00	$2,808.00
45-49	$4,128.00	$3,732.00	$3,312.00
50-54	$4,956.00	$4,452.00	$3,960.00
55-59	$5,784.00	$5,208.00	$4,620.00
60-64	$6,804.00	$6,132.00	$5,448.00
65+	$6,804.00	$6,132.00	$5,448.00

Zone 1 = ZIP codes **532__;** generally the greater Milwaukee area.
Zone 2 = ZIP codes **530__, 531__, 534__,** and **537__;** generally Madison area and southeastern Wisconsin, excluding Milwaukee.
Zone 3 = All other ZIP codes; generally central and northern Wisconsin.

Health Insurance Risk Sharing Plan (HIRSP) Zones



Zone 1 = ZIP codes 532_ _

Zone 2 = ZIP codes 530_ _, 531_ _, 534_ _, and 537_ _

Zone 3 = All other ZIP codes

Appendix 4

Methodology for Calculating HIRSP Premiums

Statutory Requirements

HIRSP premium rates are established under the following statutory authority:

- Plan 1, Option A, the $1,000 deductible plan, established under s.149.14(2)(a). s.149.143(1)(am)., Wis. Stats., states that premiums must be set at not lower than 140%, and not higher than 200%, of the rate that a standard risk would be charged under an individual policy providing substantially the same coverage and deductibles.

- Plan 1, Option B, the $2,500 deductible plan, established under s.149.146(1)(a). s.149.146(2) and (b), Wis. Stats., states that the $2,500 deductible plan rates are to be set such that they differ from Plan 1, Option A' s $1,000 deductible rates by the same percentage difference that would be found between commercially available $1,000 and $2,500 deductible plans that offer substantially the same coverage.

- Plan 2, the plan for Medicare eligibles, established under s.149.14(2)(b) and s.149.14(5m), Wis. Stats., and created by 1999 Wisconsin Act 165, states that premiums are to be determined based on the following factors:

  - ✓ A comparison between Plan 1, Option A and Plan 2 of the average per capita amount of covered expenses paid by the plan in the previous calendar year.
  - ✓ Plan 2 enrollment levels.
  - ✓ Other economic factors that the DHFS and the board consider relevant.

In addition, s.149.143 (1)(am), Wis. Stats., requires that HIRSP policyholder premiums fund 60% of plan costs but cannot be less than 140% nor more than 200% of standard risk rate.

The following paragraphs describe how the HIRSP actuaries calculate premium rates to meet these statutory requirements.

Projecting Costs

The actuaries project HIRSP costs for each plan year (July 1 through June 30) by evaluating enrollment and cost trends to estimate HIRSP claim costs for the upcoming year. In addition, they project administrative and other operating costs based on the previous year' s experience, and changes anticipated in the upcoming year.

In 2003, the General Purpose Revenue appropriation to offset plan costs was subtracted from the projected program costs to determine the adjusted operating and administrative costs for the upcoming plan year. The department and board, with the technical support of the actuaries, then determined the amount of premium revenue needed to cover 60% of the adjusted costs.

Calculating Plan-Specific Premium Rates

Premiums for the three HIRSP plans are set differently. Following is an explanation of how each plan' s rates are set.

Plan 1, Option A

The HIRSP actuaries first determine the standard industry rate that would be charged in Wisconsin under an individual policy that provides substantially the same coverage as HIRSP. These standard industry rates are determined as follows:

- Premium rates and market shares for individual "standard risks" are obtained from carriers in Wisconsin through a standard survey conducted each year. The companies used to develop the HIRSP premium rates as a function of standard risk rates are those making up approximately 90% of in-force policies in the previous year. Premium rates vary by age and gender.

- Rates for each carrier are adjusted to develop a standard risk rate for Plan 1, Option A HIRSP benefits. The current standard medical benefit (Plan 1, Option A) design of HIRSP includes a $1,000 deductible with 80% coverage of the next $5,000 and 100% thereafter. The prescription drug benefit covers 80% of each prescription with a maximum coinsurance for the policyholder of $25 per prescription. There is also a maximum prescription drug out-of-pocket limit of $750. Adjustments are made to account for differences in each carrier' s product compared to the HIRSP product.

- Each carrier' s rates are trended to the contract period. Since each carrier' s rates have a different effective date, the rates need to be increased for expected trends to the contract period of July 1-June 30, to equate to the HIRSP fiscal year. This trend rate is meant to be consistent with the average expected rate increases taken by carriers in developing their rates.

- Rates by age and gender are composite, reflecting the market share of in-force policies for each insurance carrier.

- Amounts are added for a maternity benefit provided by HIRSP that is not available from any of the carriers.

- Rates are adjusted to account for area differences within the state. Area rating is used because of the wide variation in medical care costs by geographic area. In general, both charges and utilization are higher in urban areas. The 532__ ZIP codes are the highest cost areas. The ZIP codes surrounding the 532__ ZIP codes are 10% lower, and all other ZIP codes for the state are 20% lower.

The Plan 1, Option A ($1,000 deductible plan) HIRSP premium rates are calculated to comply with the 60% premium funding share requirement and the standard risk rate parameters (not less than 140% nor more than 200%) specified in statutes.

A policyholder enrolled in Plan 1, Option A may qualify for a reduced premium if the policyholder' s annual household income is below $25,000. In accordance with s. 149.165, Wisconsin Statutes, reduced premiums are calculated as follows:

Annual Household Income	Premium at Percent of Standard Risk Rate
Less than $10,000	100% of standard risk rate
$10,000 - $13,999	106.5% of standard risk rate
$14,000 - $16,999	115.5% of standard risk rate
$17,000 - $19,999	124.5% of standard risk rate
$20,000 - $24,999	130% of standard risk rate

Plan 1, Option B

Premiums for Plan 1, Option B are set based on the relationship of a $2,500 deductible plan versus a $1,000 deductible plan found in commercially available equivalent policies.

Plan 2

With the absence of a private market plan comparable to HIRSP' s Plan 2, Plan 2 rates have historically been set at two-thirds of Plan 1, Option A rates. In 1999, the HIRSP actuaries analyzed plans available in the private market, and applied actuarial adjustments to include prescription drug coverage to construct a standard rate for Plan 2. The result of this analysis indicated that Plan 2 premiums would need to be increased by 66% to be set at 150% of the standard rate.

Statutes were revised in 1999 under Wisconsin Act 165 for setting Plan 2 rates. The statutes require the Board to set the rates using judgment considering the following factors:

- Comparison of the cost per capita for Plan 1, Option A and Plan 2 in the previous calendar year.
- The enrollment levels of eligible persons in Plan 1, Option A and Plan 2.
- Other economic factors that the department and the Board consider relevant.

HIRSP has been gradually increasing Plan 2 premium percentages to bring Plan 2 and Plan 1 loss ratios closer together over time. Plan 2 rates were 73% of Plan 1, Option A rates in the first six months of 2003, and 76% of Plan 1, Option A in the last six months of 2003.

Setting the Final Rates

In the first step, the actuaries determine how much premium revenue must be collected to cover 60% of plan costs projected for the upcoming plan year. In the second step, the actuaries determine rates based on other statutory requirements. The actuaries project the amount of premium revenue that will result from rates set according to the methodology described above.

If, based on the projected plan costs, premium revenue would be insufficient to cover 60% of plan costs; any excess premium revenues accumulated from the prior year' s reconciliation balance may be used to cover the difference. To the extent that the rates, plus any excess premium revenues from the prior year, are still insufficient to pay 60% of plan costs, premium rates will be increased to more than 140% of standard, but not more than 200% of standard. If setting rates at 200% of standard risk is still insufficient to cover 60% of plan costs, HIRSP will, according to s. 149.143, Wisconsin Statutes, increase insurer assessments and provider reimbursement discounts in equal proportions to the amount needed to cover 60%.

If premium revenue exceeds the amount needed to cover 60% of plan costs, HIRSP is required by s. 149.143(2m), Wisconsin Statutes, to keep a separate accounting of the excess premium revenue. The excess premium revenue would be used in future plan years to reduce premium increases should the need arise to have premiums higher than 140% of standard risk, or to be used for other needs of eligible persons, with the approval of the HIRSP Board of Governors.

The HIRSP Board of Governors must approve changes to premium rates. After approval by the board, the DHFS files the new rates with OCI, and amends the HIRSP Administrative Rule, HFS 119, Wisconsin Administrative Code, after first holding a public hearing on the changes to premium rates, insurer assessments and provider rate reductions that are being implemented.

Appendix 5

HIRSP Calendar Year 2003 Reconciliation[7]

Calendar Year 2003 Reconciliation	
	2003 Total
Operating and Administrative Costs (s. 149.143[1], Wis. Stats.)	
Losses Paid or Approved for Payment	118,509,148
Increase (Decrease) in Unpaid Losses	4,678,967
Drug Rebates	(815,611)
Total Administrative Expenses	5,148,407
Loss Adjustment Expense	0
Total Operating Expense	127,520,911
Adjustments to Operating and Administrative Costs	
GPR Appropriation (s. 20.435[4][af], Wis. Stats.)	4,749,996
Total Non-Operating Revenue (Expense)	381,703
Total CY Program Costs to be Split 60%, 20%, 20%	122,389,212
Adjusted Program Costs (s.149.143[1], Wis. Stats.) (Excluding Subsidy Costs)	
Funding Shares	
60% Policyholders	73,433,528
20% Providers	24,477,842
20% Insurers	24,477,842
Subsidy Funding Shares	
Premium Subsidies	4,219,178
Deductible Subsidies	694,913
Total Subsidies	4,914,091
Subsidy GPR	0
Subsidy Funding Needed in Excess of State GPR	4,914,091
Non-GPR Subsidy Funding Needed in Addition to Section 3 Funding Shares	
Providers	2,457,048
Insurers	2,457,043
Adjusted Program Costs (s. 149.143[1], Wis. Stats.) (Including Subsidy Costs)	
Policyholders	73,433,528
Providers	26,934,890
Insurers	26,934,885
Non-GPR Revenues by Source Including GPR Subsidies (s. 20.435[4][ah], Wis. Stats.)	
Policyholders	
Premium	73,700,636
Premium and Deductible Subsidies Credited to Policyholders	4,914,091
Subtotal	78,614,727
Providers	30,825,729
Insurers	28,776,174
State Subsidies	0
TOTAL	138,216,630

[7] Per reconciliation approved by Board of Governors.

Estimate of Surplus/(Deficit) Account Balance for CY 2003

Policyholders	
Prior Period Surplus/(Deficit)	6,678,398
Premium (Including Premium and Deductible Subsidies)	78,614,727
Less Cost	73,433,528
Change	5,181,199
Ending Surplus/(Deficit)	11,859,597

Providers	
Prior Period Surplus/(Deficit)	(2,573,555)
Contribution	30,825,729
Less Cost	26,934,890
Less Premium Subsidy Underpayment	223,967
Change	3,666,872
Ending Surplus/(Deficit)	1,093,317

Insurers	
Prior Period Surplus/(Deficit)	1,152,689
Assessment	28,776,174
Less Cost	26,934,885
Less Premium Subsidy Underpayment	223,966
Change	1,617,323
Ending Surplus/(Deficit)	2,770,012

Unfunded Deductible Subsidy

Prior Period Surplus/(Deficit)	(1,241,649)
Change	(694,913)
Ending Surplus/(Deficit)	(1,936,562)

Total HIRSP Retained Earnings	13,786,364

Key:

CY: Calendar Year
FY: Fiscal Year
SFY: State Fiscal Year
GPR: General Purpose Revenue

Appendix 6
History

Historical Overview

In the mid-1970s, several health policy initiatives began which would later result in the creation of HIRSP. The Center for Public Representation, a Madison-based public interest law firm, established the Handicap Law Project to assess the problems of persons with disabilities in meeting rising health care costs. The Center worked with a variety of groups — the Mental Health Association in Wisconsin, the Wisconsin Epilepsy Foundation, and the Curative Workshop of Milwaukee. These groups found that many disabled persons in Wisconsin could not obtain health insurance in the private market because of their medical conditions.

During approximately the same time period, the National Association of Insurance Commissioners (NAIC) and the Conference of Insurance Legislators (COIL) were developing model legislation to help states provide insurance coverage to the medically uninsurable. The models developed by NAIC and COIL were based on a risk-pooling concept. The basic idea of risk pooling was to charge medically uninsurable individuals higher-than-average premiums and deductibles in exchange for adequate health coverage. The premiums and deductibles, in combination with assessments on health insurers across the state, would fund health insurance claims for this select group.[8]

When HIRSP was created in 1979, it was based on the risk-pooling concept. At that time, the OCI oversaw HIRSP program administration and the HIRSP Board of Governors played a supervisory role.

1997 Wisconsin Act 27 was the first of several Wisconsin Acts in recent years to mandate a number of significant changes to HIRSP. This act made some changes to address financial, management, and administrative issues related to HIRSP. These changes are summarized below.

Historical Legislation

1997 Wisconsin Act 27

Highlights of some of the HIRSP changes enacted by 1997 Wisconsin Act 27 follow:

- *Oversight responsibility for the plan:*
  - ✓ Effective January 1, 1998, oversight responsibility for HIRSP was transferred from the OCI to the DHFS.

[8] Goldman, Amie. Health Insurance Risk Sharing Plan. Informational Paper #54. Wisconsin Legislative Fiscal Bureau. Madison, WI: January 1999.

- ✓ Included with the transfer to the DHFS, HIRSP' s daily program operations were transferred to the state' s Medicaid fiscal agent, permitting HIRSP to use common and current methods employed by Medicaid fee-for-service and managed care programs to contain costs.

- *Compliance with Health Insurance Portability and Accountability Act (HIPAA) requirements:*

  - ✓ HIRSP' s lifetime benefit increased from $500,000 to $1,000,000.

  - ✓ Pre-existing condition waiting periods were eliminated for policyholders entering the plan under the definition of "eligible individual."

  - ✓ An alternate benefit plan (Plan 1, Option B) was established, allowing for a $2,500 deductible.

  - ✓ Wisconsin designated HIRSP as the "alternate mechanism" used to comply with the law requiring assurance of portability in the individual market. This provision opened HIRSP to individuals who qualify due to losing their employer-sponsored group health insurance.

- *Increase in financial support of plan:*

  1997 Wisconsin Act 27 increased financial support for HIRSP in the following ways:

  - ✓ By making general purpose revenue funding available to offset plan costs.

  - ✓ By requiring health care providers to fund 20% of plan costs through reduced payments. This was facilitated by the requirement that plan participants receive medical services only from Wisconsin Medicaid certified providers.

  - ✓ By requiring that insurers and providers equally fund any deficit after all other financial sources have been exhausted.

<u>1999 Wisconsin Act 9</u>

1999 Wisconsin Act 9 increased the household income eligibility limit for premium reductions from $20,000 to $25,000.

<u>1999 Wisconsin Act 165</u>

1999 Wisconsin Act 165 specified the methodology to set Plan 2 premium rates.

2001 Wisconsin Act 16

2001 Wisconsin Act 16 required HIRSP to implement a case management pilot program and also to cover hospice care services when provided by a licensed hospice care provider. Most significantly, the act amended the HIRSP policy to separate drug benefits from medical benefits by establishing a separate coinsurance for prescription drugs.

This new drug benefit was implemented January 1, 2002. Under this new plan:

- Policyholders no longer pay the entire cost of their prescriptions up front if they have not satisfied medical deductible requirements.
- Policyholders are charged a 20% drug coinsurance based on the HIRSP allowed amounts for drug charges, up to a maximum of $25 per prescription.
- Policyholders now have a drug coinsurance out-of-pocket maximum, which varies by plan, option, and level of deductible for applicable policyholders.
- Prescription drug benefits no longer apply to the policyholder' s medical deductible, medical coinsurance, or medical out-of-pocket maximums.

2003 Wisconsin Act 33

Highlights of the HIRSP changes enacted by 2003 Wisconsin Act 33 are listed below:

GPR Supplement

- Eliminate all GPR that is used to partially support the Health Insurance Risk-Sharing Plan (HIRSP), including funding budgeted to offset total programming costs and to partially support the costs of premium subsidies provided to low-income policyholders.

Subsidy

- Authorize DHFS to provide subsidies for prescription drug copayments, in addition to subsidies for premiums and deductibles as provided under current law, for eligible individuals based on income levels. Specify that the costs for subsidies for premiums, deductibles, and prescription drug copayments would be distributed equally between insurers and providers.

Procurement

- Repeal the current requirement that the HIRSP plan administrator be the medical assistance (MA) fiscal agent. Instead, authorize DHFS to select the HIRSP plan administrator through a competitive bidding process. Additionally, delete the requirement that DHFS prepare the RFP not later than the first day of the seventh month beginning after the bill' s general effective date. In addition delete the requirement that DHFS submit the RFP to the Committee under a 14-day passive review process before soliciting bids.

Appendix 7

Funding Needs by Source[9]

Calendar Year	1999	2000	2001	2002	2003
Average numbers of policyholders	7,561	9,154	11,694	14,775	17,005
Plan costs per reconciliation (including deductible subsidies)*+	$48,804,352	$53,148,049	$75,329,596	$102,454,330	$127,520,911
- Miscellaneous income	(427,540)	(679,443)	(656,463)	(321,038)	(381,703)
+ Premium subsidies	1,730,945	1,982,750	1,778,683	2,977,769	4,219,178
Total plan costs	$50,107,757	$54,451,356	$76,451,816	$105,111,061	$131,358,386
Total cost per HIRSP policy	$6,627	$5,948	$6,538	$7,114	$7,725
GPR-operations	$10,900,000	$10,900,000	$10,950,018	$9,750,006	$4,749,996
GPR-subsidies	780,800	780,800	774,190	748,409	0
Insurer assessment including subsidies	8,216,318	9,165,820	13,492,607	19,966,420	26,934,885
Provider contribution including subsidies	8,216,318	9,165,820	13,492,611	19,966,426	26,934,890
Total cost of HIRSP to non- policyholders	**$28,113,437**	**$30,012,440**	**$38,709,426**	**$50,431,261**	**$58,619,771**
Cost to non-HIRSP policyholders per HIRSP policy	**$3,718**	**$3,279**	**$3,310**	**$3,413**	**$3,447**
Percent of plan costs paid by non-HIRSP Policyholders	**56.1%**	**55.1%**	**50.6%**	**48.0%**	**44.6%**
Total plan costs	$50,107,757	$54,451,356	$76,451,816	$105,111,061	$131,358,386
- Non-HIRSP policyholder cost	(28,113,437)	(30,012,440)	(38,709,426)	(50,431,261)	(58,619,771)
Difference paid by policyholder premiums	$21,994,320	$24,438,916	$37,742,390	$54,679,800	$72,738,615
Avg. per HIRSP policy borne by HIRSP PH	$2,909	$2,670	$3,228	$3,701	$4,277
Percent of plan costs paid by HIRSP PH	43.9%	44.9%	49.4%	52.0%	55.4%
Funding by source:					
GPR %	23.3%	21.5%	15.3%	10.0%	3.6%
Insurers	16.4%	16.8%	17.6%	19.0%	20.5%
Providers	16.7%	16.8%	17.6%	19.0%	20.5%
Policyholders	43.9%	44.9%	49.4%	52.0%	55.4%
Total	100.0%	100.0%	100.0%	100.0%	100.00%

* Unallocated Deductible Subsidies — Due to the way the statutes are written, deductible subsidies are counted twice when determining plan costs but are only allocated once. Therefore, an amount equal to the deductible subsidies is not allocated under the HIRSP program. Unless there is a change to the statutes, the HIRSP program will be underfunded each year by an amount equal to the deductible subsidies. The unallocated amount for the deductible subsidy at year-end in 2001, 2002, and 2003 were $491,477, $750,172, and $694,913 respectively.

+ When the change was made from Cash to Accrual Accounting, an amount equal to the Unallocated Deductible Subsidies was added to cost in 1998-2000 and was included as part of the negative retained earnings as of 12/31/00. As such, these costs were split 60%/20%/20% among the funding parties. The amounts of the deductible subsidies in 1998, 1999, and 2000 were $537,897, $491,767, and $502,246, respectively. However, in the future, an amount equal to the deductible subsidies will be unallocated unless there is a change in the statutes.

Key:
GPR: General Purpose Revenue
PH: Policyholder

[9] Milliman

Appendix 8

Insurer Rejections Resulting in Applications to HIRSP (based on approved applications)

Notice Of Rejection by:	2003 Total	2002 Total	2003 vs. 2002
BC&BS United of WI	746	886	-140
Fortis	388	466	-78
Golden Rule	386	558	-172
WPS	351	390	-39
Mega Life and Health	269	295	-26
American Family	227	232	-5
Humana Insurance Co.	211	1	210
Security Health Plan	108	180	-72
AMS/American Medical Security	107	173	-66
Midwest National Life Ins.	85	23	62
Pekin	82	110	-28
John Alden Life Ins. Co.	54	26	28
Valley Health Plan	40	41	-1
Midwest Security	38	144	-106
Atrium	35	28	7
American Republic	34	68	-34
Dean Health Plan	27	32	-5
Group Health Cooperative	1	4	-3
Physicians Plus	23	49	-26
Celtic	23	25	-2
Unity	21	4	17
Empire Fire and Marine	20	9	11
EPIC Life Insurance Co.	19	35	-16
Continental General Ins. Co.	14	6	8
American National Life	11	49	-38
World	9	25	-16
Physicians Mutual Ins. Co.	8	1	7
National Health Protection Plan	5	55	-50
United Wisconsin Life	5	0	5
Compcare	2	7	-5
Trustmark	2	5	-3

Notice Of Rejection by:	2003 Total	2002 Total	2003 vs. 2002
Bankers Life	2	4	-2
Fidelity Security Life	2	2	0
State Farm	2	1	1
Claredon National	2	0	2
Connecticut General Life	1	28	-27
Continental Assurance Co.	1	9	-8
Central Reserve Life Ins.	1	3	-2
Medica Health Plans of WI	1	3	-2
American Reliable	1	1	0
Life Investors	1	1	0
American Life and Health	1	0	1
Investors Life of North America	1	0	1
Midland National	1	0	1
Unicare Life and Health	1	0	1
United States Life	1	0	1
Wausau Preferred Health	1	0	1
WI National	1	0	1
Insurance Co. of North Am.	0	56	-56
Mutual of Omaha	0	32	-32
CONSECO	0	31	-31
Guarantee Trust Life Ins.	0	7	-7
Managed Health Services	0	5	-5
United Healthcare	0	5	-5
American Casualty Co.	0	3	-3
National Travelers Life Ins.	0	2	-2
GE Life & Annuity	0	1	-1
Guarantee Reserve Life	0	1	-1
Minnesota Life	0	1	-1
Reliance Insurance Co.	0	1	-1
Washington National Co.	0	1	-1

Appendix 9

Chapter 149 of the Wisconsin Statutes

CHAPTER 149

MANDATORY HEALTH INSURANCE RISK–SHARING PLAN

149.10 Definitions. In this chapter:

(2) "Board" means the board of governors established under s. 149.15.

(2c) "Church plan" has the meaning given in section 3 (33) of the federal Employee Retirement Income Security Act of 1974.

(2f) "Commissioner" means the commissioner of insurance.

(2j) (a) Except as provided in par. (b), "creditable coverage" means coverage under any of the following:

1. A group health plan.
2. Health insurance.
3. Part A or part B of title XVIII of the federal Social Security Act.
4. Title XIX of the federal Social Security Act, except for coverage consisting solely of benefits under section 1928 of that act.
5. Chapter 55 of title 10 of the United States Code.
6. A medical care program of the federal Indian health service or of an American Indian tribal organization.
7. A state health benefits risk pool.
8. A health plan offered under chapter 89 of title 5 of the United States Code.
9. A public health plan.
10. A health coverage plan under section 5 (e) of the federal Peace Corps Act, 22 USC 2504 (e).

(b) "Creditable coverage" does not include coverage consisting solely of coverage of excepted benefits, as defined in section 2791 (c) of P.L. 104–191.

(2m) "Department" means the department of health and family services.

(2t) "Eligible individual" means an individual for whom all of the following apply:

(a) The aggregate of the individual's periods of creditable coverage is 18 months or more.

(b) The individual's most recent period of creditable coverage was under a group health plan, governmental plan, federal governmental plan or church plan, or under any health insurance offered in connection with any of those plans.

(c) The individual does not have creditable coverage and is not eligible for coverage under a group health plan, part A or part B of title XVIII of the federal Social Security Act or a state plan under title XIX of the federal Social Security Act or any successor program.

(d) The individual's most recent period of creditable coverage was not terminated for any reason related to fraud or intentional misrepresentation of material fact or a failure to pay premiums.

(e) If the individual was offered the option of continuation coverage under a federal continuation provision or similar state program, the individual elected the continuation coverage.

(f) The individual has exhausted any continuation coverage under par. (e).

(3) "Eligible person" means a resident of this state who qualifies under s. 149.12 whether or not the person is legally responsible for the payment of medical expenses incurred on the person's behalf.

(3c) "Federal continuation provision" means any of the following:

(a) Section 4980B of the Internal Revenue Code of 1986, except for section 4980B (f) (1) of that code insofar as it relates to pediatric vaccines.

(b) Part 6 of subtitle B of title I of the federal Employee Retirement Income Security Act of 1974, except for section 609 of that act.

(c) Title XXII of P.L. 104–191.

(3d) "Federal governmental plan" means a benefit program established or maintained for its employees by the government of the United States or by any agency or instrumentality of the government of the United States.

(3e) "Fund" means the health insurance risk–sharing plan fund.

(3g) "Governmental plan" has the meaning given under section 3 (32) of the federal Employee Retirement Income Security Act of 1974.

(3j) "Group health plan" means any of the following:

(a) An employee welfare plan, as defined in section 3 (1) of the federal Employee Retirement Income Security Act of 1974, to the extent that the employee welfare plan provides medical care, including items and services paid for as medical care, to employees or to their dependents, as defined under the terms of the employee welfare plan, directly or through insurance, reimbursement, or otherwise.

(b) Any program that would not otherwise be an employee welfare benefit plan and that is established or maintained by a partnership, to the extent that the program provides medical care, including items and services paid for as medical care, to present or former partners of the partnership or to their dependents, as defined under the terms of the program, directly or through insurance, reimbursement or otherwise.

(3m) "Health care coverage revenue" means any of the following:

(a) Premiums received for health care coverage.

(b) Subscriber contract charges received for health care coverage.

(c) Health maintenance organization, limited service health organization or preferred provider plan charges received for health care coverage.

(d) The sum of benefits paid and administrative costs incurred for health care coverage under a medical reimbursement plan.

(4) "Health insurance" means surgical, medical, hospital, major medical and other health service coverage provided on an expense–incurred basis and fixed indemnity policies. "Health

insurance" does not include ancillary coverages such as income continuation, short–term, accident only, credit insurance, automobile medical payment coverage, coverage issued as a supplement to liability coverage, loss of time or accident benefits.

(4c) "Health maintenance organization" has the meaning given in s. 609.01 (2).

(4m) "HIV" means any strain of human immunodeficiency virus, which causes acquired immunodeficiency syndrome.

(4p) (a) "Insurance" includes any of the following:

1. Risk distributing arrangements providing for compensation of damages or loss through the provision of services or benefits in kind rather than indemnity in money.

2. Contracts of guaranty or suretyship entered into by the guarantor or surety as a business and not as merely incidental to a business transaction.

3. Plans established and operated under ss. 185.981 to 185.985.

(b) "Insurance" does not include a continuing care contract, as defined in s. 647.01 (2).

(5) "Insurer" means any person or association of persons, including a health maintenance organization, limited service health organization or preferred provider plan offering or insuring health services on a prepaid basis, including, but not limited to, policies of health insurance issued by a currently licensed insurer, as defined in s. 600.03 (27), nonprofit hospital or medical service plans under ch. 613, cooperative medical service plans under s. 185.981, or other entity whose primary function is to provide diagnostic, therapeutic or preventive services to a defined population in return for a premium paid on a periodic basis. "Insurer" includes any person providing health services coverage for individuals on a self–insurance basis without the intervention of other entities, as well as any person providing health insurance coverage under a medical reimbursement plan to persons. "Insurer" does not include a plan under ch. 613 which offers only dental care.

(5m) "Limited service health organization" has the meaning given in s. 609.01 (3).

(6) "Medical assistance" means health care benefits provided under subch. IV of ch. 49.

(7) "Medicare" means coverage under both part A and part B of Title XVIII of the federal social security act, 42 USC 1395 et seq., as amended.

(8) "Plan" means the health care insurance plan established and administered under this chapter.

(8b) "Plan administrator" means the fiscal agent specified in s. 149.16 (1).

(8c) "Policy" means any document other than a group certificate used to prescribe in writing the terms of an insurance contract, including endorsements and riders and service contracts issued by motor clubs.

(8j) "Preexisting condition exclusion" means, with respect to coverage, a limitation or exclusion of benefits relating to a condition of an individual that existed before the individual's date of enrollment for coverage, whether or not the individual received any medical advice or recommendation, diagnosis, care or treatment related to the condition before that date.

(8m) "Preferred provider plan" has the meaning given in s. 609.01 (4).

(8p) "Premium" means any consideration for an insurance policy, and includes assessments, membership fees or other required contributions or consideration, however designated.

(9) "Resident" means a person who has been legally domiciled in this state for a period of at least 30 days or, with respect to an eligible individual, an individual who resides in this state. For purposes of this chapter, legal domicile is established by living in this state and obtaining a Wisconsin motor vehicle operator's license, registering to vote in Wisconsin or filing a Wisconsin income tax return. A child is legally domiciled in this state if the child lives in this state and if at least one of the child's parents or the child's guardian is legally domiciled in this state. A person with a developmental disability or another disability which prevents the person from obtaining a Wisconsin motor vehicle operator's license, registering to vote in Wisconsin, or filing a Wisconsin income tax return, is legally domiciled in this state by living in this state.

(10) "Secretary" means the secretary of health and family services.

(11) "State" means the same as in s. 990.01 (40) except that it also includes the Panama Canal Zone.

History: 1997 a. 27 ss. 3014 to 3024, 4814, 4817 to 4824; Stats. 1997 s. 149.10; 1999 a. 9; 2001 a. 38.

149.11 Operation of plan. The department shall promulgate rules for the operation of a plan of health insurance coverage for an eligible person which satisfies the requirements of this chapter.

History: 1979 c. 313; 1997 a. 27 s. 4825; Stats. 1997 s. 149.11.

Cross Reference: See also ch. HFS 119, Wis. adm. code.

The federal Employee Retirement Income Security Act (ERISA) preempts any state law that relates to employee benefit plans. General Split Corp. v. Mitchell, 523 F. Supp. 427 (1981).

149.115 Rules relating to creditable coverage. The commissioner, in consultation with the department, shall promulgate rules that specify how creditable coverage is to be aggregated for purposes of s. 149.10 (2t) (a) and that determine the creditable coverage to which s. 149.10 (2t) (b) and (d) applies. The rules shall comply with section 2701 (c) of P.L. 104–191.

History: 1997 a. 27 s. 4825f; 1997 a. 237; 2001 a. 16.

149.12 Eligibility determination. (1) Except as provided in subs. (1m) and (2), the board or plan administrator shall certify as eligible a person who is covered by medicare because he or she is disabled under 42 USC 423, a person who submits evidence that he or she has tested positive for the presence of HIV, antigen or nonantigenic products of HIV or an antibody to HIV, a person who is an eligible individual, and any person who receives and submits any of the following based wholly or partially on medical underwriting considerations within 9 months prior to making application for coverage by the plan:

(a) A notice of rejection of coverage from one or more insurers.

(am) A notice of cancellation of coverage from one or more insurers.

(b) A notice of reduction or limitation of coverage, including restrictive riders, from an insurer if the effect of the reduction or limitation is to substantially reduce coverage compared to the coverage available to a person considered a standard risk for the type of coverage provided by the plan.

(c) A notice of increase in premium exceeding the premium then in effect for the insured person by 50% or more, unless the increase applies to substantially all of the insurer's health insurance policies then in effect.

(d) A notice of premium for a policy not yet in effect from 2 or more insurers which exceeds the premium applicable to a person considered a standard risk by 50% or more for the types of coverage provided by the plan.

(1m) The board or plan administrator may not certify a person as eligible under circumstances requiring notice under sub. (1) (a) to (d) if the required notices were issued by an insurance intermediary who is not acting as an administrator, as defined in s. 633.01.

(2) (b) 1. Except as provided in subd. 2., no person who is covered under the plan and who voluntarily terminates the coverage under the plan is again eligible for coverage unless 12 months have elapsed since the person's latest voluntary termination of coverage under the plan.

2. Subdivision 1. does not apply to any person who is an eligible individual or to any person who terminates coverage under the plan because he or she is eligible to receive medical assistance benefits.

(e) No person on whose behalf the plan has paid out $1,000,000 or more is eligible for coverage under the plan.

(d) 1. Except as provided in subd. 2., no person who is 65 years of age or older is eligible for coverage under the plan.

2. Subdivision 1. does not apply to any of the following:

a. A person who is an eligible individual.

b. A person who has coverage under the plan on the date on which he or she attains the age of 65 years.

(e) No person who is eligible for creditable coverage, other than those benefits specified in s. 632.745 (11) (b) 1. to 12., that is provided by an employer on a self–insured basis or through health insurance is eligible for coverage under the plan.

(f) No person who is eligible for medical assistance is eligible for coverage under the plan.

(3) (a) Except as provided in pars. (b) to (e), no person is eligible for coverage under the plan for whom a premium, deductible or coinsurance amount is paid or reimbursed by a federal, state, county or municipal government or agency as of the first day of any term for which a premium amount is paid or reimbursed and as of the day after the last day of any term during which a deductible or coinsurance amount is paid or reimbursed.

(b) Persons for whom deductible or coinsurance amounts are paid or reimbursed under ch. 47 for vocational rehabilitation, under s. 49.68 for renal disease, under s. 49.685 (8) for hemophilia, under s. 49.683 for cystic fibrosis, under s. 253.05 for maternal and child health services or under s. 49.686 for the cost of drugs for the treatment of HIV infection or AIDS are not ineligible for coverage under the plan by reason of such payments or reimbursements.

(bm) Persons for whom premium costs for health insurance coverage are subsidized under s. 252.16 are not ineligible for coverage under the plan by reason of such payments.

(c) The department may promulgate rules specifying other deductible or coinsurance amounts that, if paid or reimbursed for persons, will not make the persons ineligible for coverage under the plan.

History: 1979 c. 313; 1983 a. 27, 213; 1985 a. 29, 73; 1987 a. 27, 70, 239; 1989 a. 201 s. 36; 1989 a. 332, 359; 1991 a. 39, 250; 1993 a. 27; 1995 a. 27, 407; 1997 a. 27 ss. 3025f, 4826 to 4831e; Stats. 1997 s. 149.12; 1999 a. 9.

Cross Reference: See also chs. HFS 119 and Ins 8.42, Wis. adm. code.

149.13 Participation of insurers. (1) Every insurer shall participate in the cost of administering the plan, except the commissioner may by rule exempt as a class those insurers whose share as determined under sub. (2) would be so minimal as to not exceed the estimated cost of levying the assessment. The commissioner shall advise the department of the insurers participating in the cost of administering the plan.

(2) Every participating insurer shall share in the operating, administrative and subsidy expenses of the plan in proportion to the ratio of the insurer's total health care coverage revenue for residents of this state during the preceding calendar year to the aggregate health care coverage revenue of all participating insurers for residents of this state during the preceding calendar year, as determined by the commissioner.

(3) (a) Each insurer's proportion of participation under sub. (2) shall be determined annually by the commissioner based on annual statements and other reports filed by the insurer with the commissioner. The commissioner shall assess an insurer for the insurer's proportion of participation based on the total assessments estimated by the department under s. 149.143 (2) (a) 3.

(b) If the department or the commissioner finds that the commissioner's authority to require insurers to report under chs. 600 to 646 and 655 is not adequate to permit the department, the commissioner or the board to carry out the department's, commissioner's or board's responsibilities under this chapter, the commissioner shall promulgate rules requiring insurers to report the information necessary for the department, commissioner and board to make the determinations required under this chapter.

(4) Notwithstanding subs. (1) to (3), the department, with the agreement of the commissioner, may perform various administrative functions related to the assessment of insurers participating in the cost of administering the plan.

History: 1979 c. 313; 1981 c. 83; 1981 c. 314 s. 146; 1985 a. 29; 1989 a. 187 s. 29; 1991 a. 39, 269; 1997 a. 27 ss. 4834 to 4838; Stats. 1997 s. 149.13; 2001 a. 16.

149.14 Coverage. (1) COVERAGE OFFERED. (a) The plan shall offer in an annually renewable policy the coverage specified in this section for each eligible person. If an eligible person is also eligible for medicare coverage, the plan shall not pay or reimburse any person for expenses paid for by medicare.

(b) If an individual terminates medical assistance coverage and applies for coverage under the plan within 45 days after the termination and is subsequently found to be eligible under s. 149.12, the effective date of coverage for the eligible person under the plan shall be the date of termination of medical assistance coverage.

(2) MAJOR MEDICAL EXPENSE COVERAGE. (a) The plan shall provide every eligible person who is not eligible for medicare with major medical expense coverage. Major medical expense coverage offered under the plan under this section shall pay an eligible person's covered expenses, subject to sub. (3) and deductible, copayment and coinsurance payments authorized under sub. (5), up to a lifetime limit of $1,000,000 per covered individual. The maximum limit under this paragraph shall not be altered by the board, and no actuarially equivalent benefit may be substituted by the board.

(b) The plan shall provide an alternative policy for those persons eligible for medicare which reduces the benefits payable under par. (a) by the amounts paid under medicare.

(3) COVERED EXPENSES. Except as provided in sub. (4), except as restricted by cost containment provisions under s. 149.17 (4) and except as reduced by the department under ss. 149.143 and 149.144, covered expenses for the coverage under this section shall be the payment rates established by the department under s. 149.142 for the services provided by persons licensed under ch. 446 and certified under s. 49.45 (2) (a) 11. Except as provided in sub. (4), except as restricted by cost containment provisions under s. 149.17 (4) and except as reduced by the department under ss. 149.143 and 149.144, covered expenses for the coverage under this section shall also be the payment rates established by the department under s. 149.142 for the following services and articles if the service or article is prescribed by a physician who is licensed under ch. 448 or in another state and who is certified under s. 49.45 (2) (a) 11. and if the service or article is provided by a provider certified under s. 49.45 (2) (a) 11.:

(a) Hospital services.

(b) Basic medical–surgical services, includin both in–hospital and out–of–hospital medical and surgical services, diagnostic services, anesthesia services and consultation services, subject to the limitations in this subsection.

(c) 1. Inpatient treatment in a hospital as defined in s. 632.89 (1) (c) or in a medical facility in another state approved by the board, for up to 30 days' confinement per calendar year due to alcoholism or drug abuse and up to 60 days' confinement per calendar year for nervous and mental disorders.

2. Outpatient services as defined in s. 632.89 (1) (e) for alcoholism, drug abuse or nervous and mental disorders, as follows:

a. The first $500 of covered expenses per calendar year; and

b. An additional $2,500 of covered expenses per calendar year, after satisfaction of the deductible and coinsurance requirements under sub. (5).

3. Subject to the limits under subd. 2. and to rules promulgated by the department, services for the chronically mentally ill in community support programs operated under s. 51.421.

(d) Drugs requiring a physician's prescription, subject to sub. (4c).

(e) Services of a licensed skilled nursing facility for eligible persons eligible for medicare, to the extent required by s. 632.895 (3) and for not more than an aggregate 120 days during a calendar year, if the services are of the type which would qualify as reimbursable services under medicare. Coverage under this paragraph which is not required by s. 632.895 (3) is subject to the deductible and coinsurance requirements under sub. (5).

(g) Use of radium or other radioactive materials.

(h) Oxygen.

(i) Anesthetics.

(j) Prostheses other than dental.

(k) Rental or purchase, as appropriate, of durable medical equipment or disposable medical supplies, other than eyeglasses and hearing aids.

(L) Diagnostic X–rays and laboratory tests.

(m) Oral surgery for partially or completely unerupted, impacted teeth and oral surgery with respect to tissues of the mouth when not performed in connection with the extraction or repair of teeth.

(n) Services of a physical therapist.

(nm) Hospice care provided by a hospice licensed under subch. IV of ch. 50.

(o) Transportation provided by a licensed ambulance service to the nearest facility qualified to treat the condition.

(p) For persons not eligible for medicare, services of a licensed skilled nursing facility, only to the extent required by s. 632.895 (3).

(q) Any other health insurance coverage, only to the extent required under subch. VI of ch. 632.

(r) Processing charges for blood including, but not limited to, the cost of collecting, testing, fractionating and distributing blood.

(4) EXCLUSIONS. Covered expenses for the coverage under this section shall not include the following:

(a) Any charge for treatment for cosmetic purposes other than surgery for the repair or treatment of an injury or a congenital bodily defect. Breast reconstruction of the affected tissue incident to a mastectomy shall not be considered treatment for cosmetic purposes.

(b) Care which is primarily for custodial or domiciliary purposes which do not qualify as eligible services under medicare.

(c) Any charge for confinement in a private room to the extent it is in excess of the institution's charge for its most common semiprivate room, unless a private room is prescribed as medically necessary by a physician. If the institution does not have semiprivate rooms, its most common semiprivate room charge shall be 90% of its lowest private room charge.

(d) That part of any charge for services or articles rendered or prescribed by a physician, dentist or other health care personnel that exceeds the payment rate established by the department under s. 149.142 and reduced under ss. 149.143 and 149.144 or any charge not medically necessary.

(e) Any charge for services or articles the provision of which is not within the scope of authorized practice of the institution or individual providing the services or articles.

(f) Any expense incurred prior to the effective date of coverage under the plan for the person on whose behalf the expense is incurred.

(g) Dental care except as provided in sub. (3) (m) and (q).

(h) Eyeglasses and hearing aids.

(i) Routine physical examinations, including routine examinations to determine the need for eyeglasses and hearing aids.

(j) Illness or injury due to acts of war.

(k) Services of blood donors and any fee for failure to replace the first 3 pints of blood provided to an eligible person each calendar year.

(L) Personal supplies or services provided by a hospital or nursing home, or any other nonmedical or nonprescribed supply or service.

(m) Experimental treatment, as determined by the department.

(n) Services or drugs for the treatment of infertility, impotence or sterility.

(4c) COVERAGE OF PRESCRIPTION DRUGS. (a) The department may require a pharmacist or pharmacy that provides a prescription drug to an eligible person to submit a payment claim directly to the plan administrator.

(b) The department may limit coverage of prescription drugs under sub. (3) (d) to those prescription drugs for which payment claims are submitted by pharmacists or pharmacies directly to the plan administrator.

(4m) PAYMENT IS PAYMENT IN FULL. Except for copayments, coinsurance or deductibles required or authorized under the plan, a provider of a covered service or article shall accept as payment in full for the covered service or article the payment rate determined under ss. 149.142, 149.143 and 149.144 and may not bill an eligible person who receives the service or article for any amount by which the charge for the service or article is reduced under s. 149.142, 149.143 or 149.144.

(5) DEDUCTIBLES, COPAYMENTS, COINSURANCE, AND OUT–OF–POCKET LIMITS. (a) The plan shall offer a deductible in combination with appropriate premiums determined under this chapter for major medical expense coverage required under this section. For coverage offered to those persons eligible for medicare, the plan shall offer a deductible equal to the deductible charged by part A of title XVIII of the federal social security act, as amended. The deductible amounts for all other eligible persons shall be dependent upon household income as determined under s. 149.165. For eligible persons under s. 149.165 (2) (a) 1., the deductible shall be $500. For eligible persons under s. 149.165 (2) (a) 2., the deductible shall be $600. For eligible persons under s. 149.165 (2) (a) 3., the deductible shall be $700. For eligible persons under s. 149.165 (2) (a) 4., the deductible shall be $800. For all other eligible persons who are not eligible for medicare, the deductible shall be $1,000. With respect to all eligible persons, expenses used to satisfy the deductible during the last 90 days of a calendar year shall also be applied to satisfy the deductible for the following calendar year.

(b) Except as provided in pars. (c) and (e), if the covered costs incurred by the eligible person exceed the deductible for major medical expense coverage in a calendar year, the plan shall pay at least 80% of any additional covered costs incurred by the person during the calendar year.

(c) Except as provided in par. (e), if the aggregate of the covered costs not paid by the plan under par. (b) and the deductible exceeds $500 for an eligible person receiving medicare, $2,000 for any other eligible person during a calendar year or $4,000 for all eligible persons in a family, the plan shall pay 100% of all covered costs incurred by the eligible person during the calendar year after the payment ceilings under this paragraph are exceeded.

(d) Notwithstanding pars. (a) to (c), the department may establish different deductible amounts, a different coinsurance percentage and different covered costs and deductible aggregate amounts from those specified in pars. (a) to (c) in accordance with cost containment provisions established by the department under s. 149.17 (4).

(e) Subject to sub. (8) (b), the department may, by rule under s. 149.17 (4), establish for prescription drug coverage under sub. (3) (d) copayment amounts, coinsurance rates, and copayment and coinsurance out–of–pocket limits over which the plan will pay 100% of covered costs under sub. (3) (d). Any copayment amount, coinsurance rate, or out–of–pocket limit established under this paragraph is subject to the approval of the board. Copayments and coinsurance paid by an eligible person under this

paragraph are separate from and do not count toward the deductible and covered costs not paid by the plan under pars. (a) to (c).

(5m) PREMIUM RATES. For the coverage required under this section, the premium rates charged to eligible persons with coverage under sub. (2) (b) shall be determined on the basis of the following factors:

(a) A comparison between the average per capita amount of covered expenses paid by the plan in the previous calendar year on behalf of eligible persons with coverage under sub. (2) (b) and the average per capita amount of covered expenses paid by the plan in the previous calendar year on behalf of eligible persons with coverage under sub. (2) (a).

(b) The enrollment levels of eligible persons with coverage under sub. (2) (b).

(c) Other economic factors that the department and the board consider relevant.

(6) PREEXISTING CONDITIONS. (a) Except as provided in par. (b), no person who obtains coverage under the plan may be covered for any preexisting condition during the first 6 months of coverage under the plan if the person was diagnosed or treated for that condition during the 6 months immediately preceding the filing of an application with the plan.

(b) An eligible individual who obtains coverage under the plan may not be subject to any preexisting condition exclusion under the plan.

(7) COORDINATION OF BENEFITS. (a) Covered expenses under the plan shall not include any charge for care for injury or disease for which benefits are payable without regard to fault under coverage statutorily required to be contained in any motor vehicle or other liability insurance policy or equivalent self–insurance, for which benefits are payable under a worker's compensation or similar law, or for which benefits are payable under another policy of health care insurance, medicare, medical assistance or any other governmental program, except as otherwise provided by law.

(b) The department has a cause of action against an eligible participant for the recovery of the amount of benefits paid which are not for covered expenses under the plan. Benefits under the plan may be reduced or refused as a setoff against any amount recoverable under this paragraph.

(c) The department is subrogated to the rights of an eligible person to recover special damages for illness or injury to the person caused by the act of a 3rd person to the extent that benefits are provided under the plan. Section 814.03 (3) applies to the department under this paragraph.

(8) APPLICABILITY OF MEDICAL ASSISTANCE PROVISIONS. (a) Except as provided in par. (b), the department may, by rule under s. 149.17 (4), apply to the plan the same utilization and cost control procedures that apply under rules promulgated by the department to medical assistance under subch. IV of ch. 49.

(b) The department may not apply to eligible persons for covered services or articles the same copayments that apply to recipients of medical assistance under subch. IV of ch. 49 for services or articles covered under that program.

History: 1979 c. 313; 1981 c. 39 s. 22; 1981 c. 83; 1981 c. 314 ss. 117, 146; 1983 a. 27; 1985 a. 29 s. 3202 (30); 1985 a. 332 s. 253; 1987 a. 27, 239; 1989 a. 332; 1991 a. 39, 269; 1995 a. 463; 1997 a. 27 ss. 3026c, 4847 to 4859; Stats. 1997 s. 149.14; 1997 a. 237; 1999 a. 9, 165; 2001 a. 16.

Cross Reference: See also s. HFS 119.12, Wis. adm. code.

149.142 Provider payment rates. (1) (a) Except as provided in par. (b), the department shall establish payment rates for covered expenses that consist of the allowable charges paid under s. 49.46 (2) for the services and articles provided plus an enhancement determined by the department. The rates shall be based on the allowable charges paid under s. 49.46 (2), projected plan costs and trend factors. Using the same methodology that applies to medical assistance under subch. IV of ch. 49, the department shall establish hospital outpatient per visit reimbursement rates and hospital inpatient reimbursement rates that are specific to diagnostically related groups of eligible persons.

(b) The payment rate for a prescription drug shall be the allowable charge paid under s. 49.46 (2) (b) 6. h. for the prescription drug. Notwithstanding s. 149.17 (4), the department may not reduce the payment rate for prescription drugs below the rate specified in this paragraph, and the rate may not be adjusted under s. 149.143 or 149.144.

(2) Except as provided in sub. (1) (b), the rates established under this section are subject to adjustment under ss. 149.143 and 149.144.

History: 1999 a. 9; 2001 a. 16.

149.143 Payment of plan costs. (1) The department shall pay or recover the operating costs of the plan from the appropriation under s. 20.435 (4) (v) and administrative costs of the plan from the appropriation under s. 20.435 (4) (u). For purposes of determining premiums, insurer assessments and provider payment rate adjustments, the department shall apportion and prioritize responsibility for payment or recovery of plan costs from among the moneys constituting the fund as follows:

(a) First from the moneys transferred to the fund from the appropriation account under s. 20.435 (4) (af).

(b) The remainder of the costs as follows:

1. A total of 60% from the following sources, calculated as follows:

a. First, from premiums from eligible persons with coverage under s. 149.14 (2) (a) set at a rate that is 140% to 150% of the rate that a standard risk would be charged under an individual policy providing substantially the same coverage and deductibles as are provided under the plan and from eligible persons with coverage under s. 149.14 (2) (b) set in accordance with s. 149.14 (5m), including amounts received for premium and deductible subsidies under s. 149.144 and under the transfer to the fund from the appropriation account under s. 20.435 (4) (ah), and from premiums collected from eligible persons with coverage under s. 149.146 set in accordance with s. 149.146 (2) (b).

b. Second, from moneys specified under sub. (2m), to the extent that the amounts under subd. 1. a. are insufficient to pay 60% of plan costs.

c. Third, by increasing premiums from eligible persons with coverage under s. 149.14 (2) (a) to more than the rate at which premiums were set under subd. 1. a. but not more than 200% of the rate that a standard risk would be charged under an individual policy providing substantially the same coverage and deductibles as are provided under the plan and from eligible persons with coverage under s. 149.14 (2) (b) by a comparable amount in accordance with s. 149.14 (5m), including amounts received for premium and deductible subsidies under s. 149.144 and under the transfer to the fund from the appropriation account under s. 20.435 (4) (ah), and by increasing premiums from eligible persons with coverage under s. 149.146 in accordance with s. 149.146 (2) (b), to the extent that the amounts under subd. 1. a. and b. are insufficient to pay 60% of plan costs.

d. Fourth, notwithstanding subd. 2., by increasing insurer assessments, excluding assessments under s. 149.144, and adjusting provider payment rates, subject to s. 149.142 (1) (b) and excluding adjustments to those rates under s. 149.144, in equal proportions and to the extent that the amounts under subd. 1. a. to c. are insufficient to pay 60% of plan costs.

2. A total of 40% as follows:

a. Fifty percent from insurer assessments, excluding assessments under s. 149.144.

b. Fifty percent from adjustments to provider payment rates, subject to s. 149.142 (1) (b) and excluding adjustments to those rates under s. 149.144.

(2) (a) Prior to each plan year, the department shall estimate the operating and administrative costs of the plan and the costs of the premium reductions under s. 149.165 and the deductible reductions under s. 149.14 (5) (a) for the new plan year and do all of the following:

1. a. Estimate the amount of enrollee premiums that would be received in the new plan year if the enrollee premiums were set at a level sufficient, when including amounts received for premium and deductible subsidies under s. 149.144 and under the transfer to the fund from the appropriation account under s. 20.435 (4) (ah) and from premiums collected from eligible persons with coverage under s. 149.146 set in accordance with s. 149.146 (2) (b), to cover 60% of the estimated plan costs for the new plan year, after deducting from the estimated plan costs the amount available for transfer to the fund from the appropriation account under s. 20.435 (4) (af) for that plan year.

b. Estimate the amount of enrollee premiums that will be received under sub. (1) (b) 1. a.

2. After making the determinations under subd. 1., by rule set premium rates for the new plan year, including the rates under s. 149.146 (2) (b), in the manner specified in sub. (1) (b) 1. a. and c. and such that a rate for coverage under s. 149.14 (2) (a) is approved by the board and is not less than 140% nor more than 200% of the rate that a standard risk would be charged under an individual policy providing substantially the same coverage and deductibles as are provided under the plan.

3. By rule set the total insurer assessments under s. 149.13 for the new plan year by estimating and setting the assessments at the amount necessary to equal the amounts specified in sub. (1) (b) 1. d. and 2. a. and notify the commissioner of the amount.

4. By the same rule as under subd. 3. adjust the provider payment rate for the new plan year, subject to s. 149.142 (1) (b), by estimating and setting the rate at the level necessary to equal the amounts specified in sub. (1) (b) 1. d. and 2. b. and as provided in s. 149.145.

(b) In setting the premium rates under par. (a) 2., the insurer assessment amount under par. (a) 3. and the provider payment rate under par. (a) 4. for the new plan year, the department shall include any increase or decrease necessary to reflect the amount, if any, by which the rates and amount set under par. (a) for the current plan year differed from the rates and amount which would have equaled the amounts specified in sub. (1) (b) in the current plan year.

(2m) (a) The department shall keep a separate accounting of the difference between the following:

1. The amount of premiums received in a plan year from all eligible persons, including amounts received for premium and deductible subsidies.

2. The amount of premiums, including amounts received for premium and deductible subsidies, necessary to cover 60% of the plan costs for the plan year, after deducting the amount transferred to the fund from the appropriation account under s. 20.435 (4) (af).

(b) Any amount by which the amount under par. (a) 1. exceeds the amount under par. (a) 2. may be used only as follows:

1. To reduce premiums in succeeding plan years as provided in sub. (1) (b) 1. b. For eligible persons with coverage under s. 149.14 (2) (a), premiums may not be reduced below 140% of the rate that a standard risk would be charged under an individual policy providing substantially the same coverage and deductibles as are provided under the plan.

2. For other needs of eligible persons, with the approval of the board.

3. For distribution to eligible persons, notwithstanding any requirements in this chapter related to setting premium amounts. The department, with the approval of the board and the concurrence of the plan actuary, shall determine the policies, eligibility criteria, methodology, and other factors to be used in making any distribution under this subdivision.

(3) (a) If, during a plan year, the department determines that the amounts estimated to be received as a result of the rates and amount set under sub. (2) (a) 2. to 4. and any adjustments in insurer assessments and the provider payment rate under s. 149.144 will not be sufficient to cover plan costs, the department may by rule increase the premium rates set under sub. (2) (a) 2. for the remainder of the plan year, subject to s. 149.146 (2) (b) and the maximum specified in sub. (2) (a) 2., by rule increase the assessments set under sub. (2) (a) 3. for the remainder of the plan year, subject to sub. (1) (b) 2. a., and by the same rule under which assessments are increased adjust the provider payment rate set under sub. (2) (a) 4. for the remainder of the plan year, subject to sub. (1) (b) 2. b. and s. 149.142 (1) (b).

(b) If the department increases premium rates and insurer assessments and adjusts the provider payment rate under par. (a) and determines that there will still be a deficit and that premium rates have been increased to the maximum extent allowable under par. (a), the department may further adjust, in equal proportions, assessments set under sub. (2) (a) 3. and the provider payment rate set under sub. (2) (a) 4., without regard to sub. (1) (b) 2. but subject to s. 149.142 (1) (b).

(3m) Subject to s. 149.14 (4m), insurers and providers may recover in the normal course of their respective businesses without time limitation assessments or provider payment rate adjustments used to recoup any deficit incurred under the plan.

(4) Using the procedure under s. 227.24, the department may promulgate rules under sub. (2) or (3) for the period before the effective date of any permanent rules promulgated under sub. (2) or (3), but not to exceed the period authorized under s. 227.24 (1) (c) and (2). Notwithstanding s. 227.24 (1) and (3), the department is not required to make a finding of emergency.

(5) (a) Annually, no later than April 30, the department shall perform a reconciliation with respect to plan costs, premiums, insurer assessments, and provider payment rate adjustments based on data from the previous calendar year. On the basis of the reconciliation, the department shall make any necessary adjustments in premiums, insurer assessments, or provider payment rates, subject to s. 149.142 (1) (b), for the fiscal year beginning on the first July 1 after the reconciliation, as provided in sub. (2) (b).

(b) Except as provided in sub. (3) and s. 149.144, the department shall adjust the provider payment rates to meet the providers' specified portion of the plan costs no more than once annually, subject to s. 149.142 (1) (b). The department may not determine the adjustment on an individual provider basis or on the basis of provider type, but shall determine the adjustment for all providers in the aggregate, subject to s. 149.142 (1) (b).

History: 1997 a. 27; 1999 a. 9, 165; 2001 a. 16, 109.
Cross Reference: See also ch. HFS 119, Wis. adm. code.

149.144 Adjustments to insurer assessments and provider payment rates for premium and deductible reductions. If the moneys transferred to the fund under the appropriation under s. 20.435 (4) (ah) are insufficient to reimburse the plan for premium reductions under s. 149.165 and deductible reductions under s. 149.14 (5) (a), or the department determines that the moneys transferred or to be transferred to the fund under the appropriation under s. 20.435 (4) (ah) will be insufficient to reimburse the plan for premium reductions under s. 149.165 and deductible reductions under s. 149.14 (5) (a), the department may, by rule, adjust in equal proportions the amount of the assessment set under s. 149.143 (2) (a) 3. and the provider payment rate set under s. 149.143 (2) (a) 4., subject to ss. 149.142 (1) (b) and 149.143 (1) (b) 1., sufficient to reimburse the plan for premium reductions under s. 149.165 and deductible reductions under s. 149.14 (5) (a). If the department makes the adjustment under this section, the department shall notify the commissioner so that the commissioner may levy any increase in insurer assessments.

History: 1997 a. 27 ss. 4840c, 4845c; 1999 a. 9; 2001 a. 16.
Cross Reference: See also ch. HFS 119, Wis. adm. code.

149.145 Program budget. The department, in consultation with the board, shall establish a program budget for each plan year. The program budget shall be based on the provider payment rates specified in s. 149.142 and in the most recent provider contracts that are in effect and on the funding sources specified in s. 149.143 (1), including the methodologies specified in ss. 149.143, 149.144, and 149.146 for determining premium rates, insurer

assessments, and provider payment rates. Except as otherwise provided in s. 149.143 (3) (a) and (b) and subject to s. 149.142 (1) (b), from the program budget the department shall derive the actual provider payment rate for a plan year that reflects the providers' proportional share of the plan costs, consistent with ss. 149.143 and 149.144. The department may not implement a program budget established under this section unless it is approved by the board.

History: 1997 a. 27; 1999 a. 9; 2001 a. 16.

149.146 Choice of coverage. (1) (a) Beginning on January 1, 1998, in addition to the coverage required under s. 149.14, the plan shall offer to all eligible persons who are not eligible for medicare a choice of coverage, as described in section 2744 (a) (1) (C), P.L. 104–191. Any such choice of coverage shall be major medical expense coverage.

(b) An eligible person under par. (a) may elect once each year, at the time and according to procedures established by the department, among the coverages offered under this section and s. 149.14. If an eligible person elects new coverage, any preexisting condition exclusion imposed under the new coverage is met to the extent that the eligible person has been previously and continuously covered under this chapter. No preexisting condition exclusion may be imposed on an eligible person who elects new coverage if the person was an eligible individual when first covered under this chapter and the person remained continuously covered under this chapter up to the time of electing the new coverage.

(2) (a) Except as specified by the department, the terms of coverage under s. 149.14, including deductible reductions under s. 149.14 (5) (a), do not apply to the coverage offered under this section. Premium reductions under s. 149.165 do not apply to the coverage offered under this section.

(am) 1. For all eligible persons with coverage under this section, the deductible shall be $2,500. Expenses used to satisfy the deductible during the last 90 days of a calendar year shall also be applied to satisfy the deductible for the following calendar year.

2. Except as provided in subds. 3. and 5., if the covered costs incurred by the eligible person exceed the deductible for major medical expense coverage in a calendar year, the plan shall pay at least 80% of any additional covered costs incurred by the person during the calendar year.

3. Except as provided in subd. 5., if the aggregate of the covered costs not paid by the plan under subd. 2. and the deductible exceeds $3,500 for any eligible person during a calendar year or $7,000 for all eligible persons in a family, the plan shall pay 100% of all covered costs incurred by the eligible person during the calendar year after the payment ceilings under this subdivision are exceeded.

4. Notwithstanding subds. 1. to 3., the department may establish different deductible amounts, a different coinsurance percentage and different covered costs and deductible aggregate amounts from those specified in subds. 1. to 3. in accordance with cost containment provisions established by the department under s. 149.17 (4).

5. Subject to s. 149.14 (8) (b), the department may, by rule under s. 149.17 (4), establish for prescription drug coverage under this section copayment amounts, coinsurance rates, and copayment and coinsurance out–of–pocket limits over which the plan will pay 100% of covered costs for prescription drugs. Any copayment amount, coinsurance rate, or out–of–pocket limit established under this subdivision is subject to the approval of the board. Copayments and coinsurance paid by an eligible person under this subdivision are separate from and do not count toward the deductible and covered costs not paid by the plan under subds. 1. to 3.

(b) The schedule of premiums for coverage under this section shall be promulgated by rule by the department, as provided in s. 149.143. The rates for coverage under this section shall be set such that they differ from the rates for coverage under s. 149.14 (2) (a) by the same percentage as the percentage difference between the following:

1. The rate that a standard risk would be charged under an individual policy providing substantially the same coverage and deductibles as provided under s. 149.14 (2) (a) and (5) (a).

2. The rate that a standard risk would be charged under an individual policy providing substantially the same coverage and deductibles as the coverage offered under this section.

History: 1997 a. 27 ss. 4860c, 4860d; Stats. 1997 s. 149.146; 1997 a. 237; 1999 a. 9, 165; 2001 a. 16.

Cross Reference: See also ch. HFS 119, Wis. adm. code.

149.15 Board of governors. (1) The plan shall have a board of governors consisting of representatives of 2 participating insurers that are nonprofit corporations, representatives of 2 other participating insurers, 3 health care provider representatives, including one representative of the State Medical Society of Wisconsin, one representative of the Wisconsin Health and Hospital Association and one representative of an integrated multidisciplinary health system, and 4 public members, including one representative of small businesses in the state, appointed by the secretary for staggered 3–year terms. In addition, the commissioner, or a designated representative from the office of the commissioner, and the secretary, or a designated representative from the department, shall be members of the board. The public members shall not be professionally affiliated with the practice of medicine, a hospital, or an insurer. At least one of the public members shall be an individual who has coverage under the plan. The secretary or the secretary's representative shall be the chairperson of the board. Board members, except the commissioner or the commissioner's representative and the secretary or the secretary's representative, shall be compensated at the rate of $50 per diem plus actual and necessary expenses.

(2) Annually, the board shall make a report to the appropriate standing committees under s. 13.172 (3) and to the members of the plan summarizing the activities of the plan in the preceding calendar year. The annual report shall define the cost burden imposed by the plan on all policyholders in this state.

(2m) Annually, beginning in 1999, the board shall submit a report on or before June 30 to the legislature under s. 13.172 (2) and to the governor on the operation of the plan, including any recommendations for changes to the plan.

(3) The board shall do all of the following:

(a) Establish procedures under which applicants and participants may have grievances reviewed by an impartial body and reported to the board.

(c) Collect assessments from all insurers to provide for claims paid under the plan and for administrative expenses incurred or estimated to be incurred during the period for which the assessment is made. The level of payments shall be established as provided under s. 149.143. Assessment of the insurers shall occur at the end of each calendar year or other fiscal year end established by the board. Assessments are due and payable within 30 days of receipt by the insurer of the assessment notice.

(d) Develop and implement a program to publicize the existence of the plan, the eligibility requirements and procedures for enrollment, and to maintain public awareness of the plan.

(f) Advise the department on the choice of coverage under s. 149.146.

(g) Establish oversight committees to address various administrative issues, such as financial management of the plan and plan administrator performance standards. A representative of the department may not be the chairperson of any committee established under this paragraph.

(4) The board may do any of the following:

(a) Prepare and distribute certificate of eligibility forms and enrollment instruction forms to insurance solicitors, agents and brokers, and to the general public in this state.

(b) Provide for reinsurance of risks incurred by the plan, and may enter into reinsurance agreements with insurers to establish a reinsurance plan for risks of coverage described in the plan, or obtain commercial reinsurance to reduce the risk of loss through the pool.

(5) The department may, by rule, establish additional powers and duties of the board.

(6) If any provision of this chapter conflicts with s. 625.11 or 625.12, this chapter prevails.

(7) (a) The board is not liable for any obligation of the plan.

(b) Members of the board are state officers for purposes of s. 895.46.

History: 1979 c. 313; 1981 c. 83; 1987 a. 186, 399; 1991 a. 269; 1997 a. 27 ss. 3027m, 3027r, 4861 to 4878; Stats. 1997 s. 149.15; 1999 a. 9; 2001 a. 16.
Cross Reference: See also ch. HFS 119, Wis. adm. code.

149.16 Plan administrator. (1) The fiscal agent under s. 49.45 (2) (b) 2. shall administer the plan.

(3) (a) The plan administrator shall perform all eligibility and administrative claims payment functions relating to the plan.

(b) The plan administrator shall establish a premium billing procedure for collection of premiums from insured persons. Billings shall be made on a periodic basis as determined by the department.

(c) The plan administrator shall perform all necessary functions to assure timely payment of benefits to covered persons under the plan, including:

1. Making available information relating to the proper manner of submitting a claim for benefits under the plan and distributing forms upon which submissions shall be made.

2. Evaluating the eligibility of each claim for payment under the plan.

3. Notifying each claimant within 30 days after receiving a properly completed and executed proof of loss whether the claim is accepted, rejected or compromised.

(e) The plan administrator, under the direction of the department, shall pay claims expenses from the premium payments received from or on behalf of covered persons under the plan. If the plan administrator's payments for claims expenses exceed premium payments, the board shall forward to the department, and the department shall provide to the plan administrator, additional funds for payment of claims expenses.

(4) The plan administrator shall account for costs related to the plan separately from costs related to medical assistance under subch. IV of ch. 49.

(5) The department shall obtain the approval of the board before implementing any contract with the plan administrator.

History: 1997 a. 27 ss. 3030, 3031, 4882 to 4884c, 4886; 1999 a. 9.

149.165 Reductions in premiums for low–income eligible persons. (1) Except as provided in s. 149.146 (2) (a), the department shall reduce the premiums established under s. 149.11 in conformity with ss. 149.14 (5m), 149.143 and 149.17 for the eligible persons and in the manner set forth in subs. (2) and (3).

(2) (a) Subject to sub. (3m), if the household income, as defined in s. 71.52 (5) and as determined under sub. (3), of an eligible person with coverage under s. 149.14 (2) (a) is equal to or greater than the first amount and less than the 2nd amount listed in any of the following, the department shall reduce the premium for the eligible person to the rate shown after the amounts:

1. If equal to or greater than $0 and less than $10,000, to 100% of the rate that a standard risk would be charged under an individual policy providing substantially the same coverage and deductibles as provided under s. 149.14 (2) (a) and (5) (a).

2. If equal to or greater than $10,000 and less than $14,000, to 106.5% of the rate that a standard risk would be charged under an individual policy providing substantially the same coverage and deductibles as provided under s. 149.14 (2) (a) and (5) (a).

3. If equal to or greater than $14,000 and less than $17,000, to 115.5% of the rate that a standard risk would be charged under an individual policy providing substantially the same coverage and deductibles as provided under s. 149.14 (2) (a) and (5) (a).

4. If equal to or greater than $17,000 and less than $20,000, to 124.5% of the rate that a standard risk would be charged under an individual policy providing substantially the same coverage and deductibles as provided under s. 149.14 (2) (a) and (5) (a).

5. If equal to or greater than $20,000 and less than $25,000, to 130% of the rate that a standard risk would be charged under an individual policy providing substantially the same coverage and deductibles as provided under s. 149.14 (2) (a) and (5) (a).

(bc) Subject to sub. (3m), if the household income, as defined in s. 71.52 (5) and as determined under sub. (3), of an eligible person with coverage under s. 149.14 (2) (b) is equal to or greater than the first amount and less than the 2nd amount listed in par. (a) 1., 2., 3., 4. or 5., the department shall reduce the premium established for the eligible person by the same percentage as the department reduces, under par. (a), the premium established for an eligible person with coverage under s. 149.14 (2) (a) who has a household income specified in the same subdivision under par. (a) as the household income of the eligible person with coverage under s. 149.14 (2) (b).

(3) (a) Subject to par. (b), the department shall establish and implement the method for determining the household income of an eligible person under sub. (2).

(b) In determining household income under sub. (2), the department shall consider information submitted by an eligible person on a completed federal profit or loss from farming form, schedule F, if all of the following apply:

1. The person is a farmer, as defined in s. 102.04 (3).

2. The person was not eligible to claim the homestead credit under subch. VIII of ch. 71 in the preceding taxable year.

(3m) The board may approve adjustment of the household income dollar amounts listed in sub. (2) (a) 1. to 5., except for the first dollar amount listed in sub. (2) (a) 1., to reflect changes in the consumer price index for all urban consumers, U.S. city average, as determined by the U.S. department of labor.

(4) The department shall reimburse the plan for premium reductions under sub. (2) and deductible reductions under s. 149.14 (5) (a) with moneys transferred to the fund from the appropriation account under s. 20.435 (4) (ah).

History: 1985 a. 29; 1987 a. 27; 1987 a. 312 s. 17; 1991 a. 39; 1997 a. 27 ss. 4889 to 4894; Stats. 1997 s. 149.165; 1999 a. 9, 165.
Cross Reference: See also s. HFS 119.12, Wis. adm. code.

149.17 Contents of plan. The plan shall include, but is not limited to, the following:

(1) Subject to ss. 149.14 (5m), 149.143 and 149.146 (2) (b), a rating plan calculated in accordance with generally accepted actuarial principles.

(2) A schedule of premiums, deductibles, copayments and coinsurance payments that complies with all requirements of this chapter.

(3) Procedures for applicants and participants to have grievances reviewed by an impartial body.

(4) Cost containment provisions established by the department by rule, including managed care requirements.

History: 1979 c. 313; 1983 a. 27; 1987 a. 27; 1991 a. 39; 1997 a. 27 ss. 4896 to 4900; Stats. 1997 s. 149.17; 1999 a. 9, 165.
Cross Reference: See also ch. HFS 119, Wis. adm. code.

149.175 Waiver or exemption from provisions prohibited. Except as provided in s. 149.13 (1), the department may not waive, or authorize the board to waive, any of the requirements of this chapter or exempt, or authorize the board to exempt, an individual or a class of individuals from any of the requirements of this chapter.

History: 1991 a. 39; 1997 a. 27 s. 4901; Stats. 1997 s. 149.175.

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149.18 Chapters 600 to 645 applicable. Except as otherwise provided in this chapter, the plan shall comply and be administered in compliance with chs. 600 to 645.

History: 1979 c. 313; 1981 c. 314; 1997 a. 27 s. 4902; Stats. 1997 s. 149.18.

149.20 Rule–making in consultation with board. In promulgating any rules under this chapter, the department shall consult with the board.

History: 1997 a. 27.

149.25 Case management pilot program. (1) DEFINITIONS. In this section:

(a) "Chronic disease" means any disease, illness, impairment, or other physical condition that requires health care and treatment over a prolonged period and, although amenable to treatment, is irreversible and frequently progresses to increasing disability or death.

(b) "Health professional shortage area" means an area that is designated by the federal department of health and human services under 42 CFR part 5, appendix A, as having a shortage of medical care professionals.

(2) PROGRAM AND ELIGIBILITY REQUIREMENTS. (a) The department shall conduct a 3–year pilot program, beginning on July 1, 2002, under which eligible persons who qualify under par. (b) are provided community–based case management services.

(b) To be eligible to participate in the pilot program, an eligible person must satisfy any of the following criteria:

1. Be diagnosed as having a chronic disease.

2. Be taking 2 or more prescribed medications on a regular basis.

3. Within 6 months of applying for the pilot program, have been treated 2 or more times at a hospital emergency room or have been admitted 2 or more times to a hospital as an inpatient.

(c) 1. Participation in the pilot program shall be voluntary and limited to no more than 300 eligible persons. The department shall ensure that all eligible persons are advised in a timely manner of the opportunity to participate in the pilot program and of how to apply for participation.

2. If more than 300 eligible persons apply to participate, the department shall select pilot program participants from among those who qualify under par. (b) according to standards determined by the department, except that the department shall give preference to eligible persons who reside in medically underserved areas or health professional shortage areas.

(3) PROVIDER ORGANIZATION AND SERVICES REQUIREMENTS. (a) The department shall select and contract with an organization to provide the community–based case management services under the pilot program. To be eligible to provide the services, an organization must satisfy all of the following criteria:

1. Be a private, nonprofit, integrated health care system that provides access to health care in a medically underserved area of the state or in a health professional shortage area.

2. Operate an existing community–based case management program with demonstrated successful client and program outcomes.

3. Demonstrate an ability to assemble and coordinate an interdisciplinary team of health care professionals, including physicians, nurses, and pharmacists, for assessment of a program participant's treatment plan.

(b) The community–based case management services under the pilot program shall be provided by a team, consisting of a nurse case manager, a pharmacist, and a social worker, working in collaboration with the eligible person's primary care physician or other provider. Services to be provided include all of the following:

1. An initial intake assessment.

2. Development of a treatment plan based on best practices.

3. Coordination of health care services.

4. Patient education.

5. Family support.

6. Monitoring and reporting of patient outcomes and costs.

(c) The department shall pay contract costs from the appropriation under s. 20.435 (4) (u).

(4) EVALUATION STUDY. The department shall conduct a study that evaluates the pilot program in terms of health care outcomes and cost avoidance. In the study, the department shall measure and compare, for pilot program participants and similarly situated eligible persons not participating in the pilot program, plan costs and utilization of services, including inpatient hospital days, rates of hospital readmission within 30 days for the same diagnosis, and prescription drug utilization. The department shall submit a report on the results of the study, including the department's conclusions and recommendations, to the legislature under s. 13.172 (2) and to the governor.

History: 2001 a. 16.